



**KAMSI HEALTHCARE CORPORATION**

Telehealth Patient Consents (Read & Sign)

Patient: \_\_\_\_\_ DOB: //\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Check + Initial each (Telehealth Only):

A) Consent for Telehealth Treatment: I consent to evaluation and treatment via telehealth (video/phone) by \_\_\_\_\_ Kamsi Healthcare Corp. For emergencies, call 911 or go to the nearest ER. Initials: \_\_\_\_\_

B) Controlled/Scheduled Prescriptions (Telehealth, incl. MOUD): I consent to clinically appropriate prescribing of scheduled/controlled medications through telehealth and agree to required safety monitoring (follow-ups, PDMP checks, UDS/pill or film counts when requested). Initials: \_\_\_\_\_

C) Communication Consent (Email / Text / Phone): I authorize Kamsi Healthcare Corp. to contact me by email, text message, and phone call (including voicemail) for non-emergency purposes such as scheduling, reminders, care coordination, forms, and billing/administrative communication. I understand these methods may not be fully secure and are not for emergencies. Initials: \_\_\_\_\_

Preferred (check all that apply):  Text  Email  Phone  Voicemail \_\_\_\_\_

D) HIPAA/NPP: I acknowledge the Notice of Privacy Practices was offered. Initials: \_\_\_\_\_

E) 42 CFR Part 2 (SUD/TPO): If I receive SUD services, I authorize Part 2-protected info use/disclosure for Treatment/Payment/Operations as permitted by law; revocable in writing (except where already relied upon). Initials: \_\_\_\_\_

F) Release of Information (ROI): I authorize release of information only as specified in a separate ROI form (HIPAA/Part 2 as applicable); revocable in writing (except where already relied upon). Initials: \_\_\_\_\_

G) AI-Assisted Documentation: I consent to use of AI-assisted documentation (AI scribe) to help draft my visit note. My clinician remains responsible for my care and will review/edit for accuracy. I may decline and still receive care. Initials: \_\_\_\_\_

H) MAT Agreement (if receiving MOUD/MAT): If I receive Medication-Assisted Treatment, I agree to follow the MAT plan and safety requirements, including attending scheduled visits, taking medication only as prescribed, not sharing/selling medication, and completing monitoring when requested (e.g., UDS, PDMP checks, pill/film counts). Initials: \_\_\_\_\_

I) Financial Responsibility: I agree I am responsible for charges not covered by insurance (including copays, coinsurance, deductibles, self-pay balances, and no-show/late-cancel fees if applicable). I authorize billing to my insurer and understand unpaid balances may be billed to me. Initials: \_\_\_\_\_

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_  
Relationship (if not patient): \_\_\_\_\_ Date: //\_\_\_\_\_