OPIOID ABUSE NEW PATIENT MEDICAL HISTORY FORM

FIRST NAME:	LAST NAME	DATE:
BIRTH GENDER:		DOB:

How does your opioid abuse affect your life and health?

___

___

OPIOID HISTORY:

When did you first notice that opioid is a problem? □ Childhood □Teens □ Adulthood

What is your opioid of choice? ___

How long can you go without taking opioids? ___ hours ___ Days ___Weeks ___

What is your average opioid intake a day?___

TRAUMA HISTORY (Life events associated with opioid abuse. Check all that apply)

□ Marriage □Injury □Pregnancy □Illness

□Travel □Drugs □Work □Quitting smoking

□Divorce □Abuse □Job Change □Other: ___

Previous Opioid Control Treatment Programs you have tried: (check all that apply)

□AA □Smart Recovery □Inpatient Rehab

□NA □Sinclair Method □Other: ___

□IOP □Church

What are your greatest challenges with controlling your opioid use?

___

___

___

Have you ever taken medication to control opioid use? (Check all that apply)

□ Kratom □Gabapentin □Suboxone/Buprenorphine

□Xanax Naltrexone □Anti-depressant Medication (which one) ___

□Zofran □Tramadol □Other:

□Methadone ___

What worked? ___

What didn't work?___

Why or why not? ___

OPIOID HISTORY CONT:

Alcohol triggers (check all that apply):

□Stress	□Insomnia	□Life changes	□ Seizure Disorder
□Boredom	□Seeking reward	□Work	□Eating out
□Anger	□Parties	□Divorce	□Other: ___________________

SLEEP HISTORY:

How many hours do you sleep per night? _______ Do you feel rested in the morning? ____________

Do you snore? □Yes □No Have you had a sleep study? □Yes □No

Do you need alcohol or opioid to sleep? □Yes □No

TRAUMA HISTORY:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No Please describe when, where, and by whom: ____

SUBTANCE ABUSE HISTORY: (Check if you have every tried the following)

☐ Methamphetamine	☐ Marijuana	☐ Estasy
☐ Cocaine	☐ Pain Killers (Not Prescribed)	☐ Alcohol
☐ Herion	☐ Methodone	☐ Other ___________________
☐ LSD or Hallucinogens	☐ Tranquilizer/Sleeping Pills	

SPIRITUAL HISTORY:

Do you belong to a particular religion or spiritual group? ☐ YES ☐ NO

If yes, What is the level of your involvement?

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?

Is there anything else you would like for us to know?

SEXUAL HISTORY:

Are you sexually Active? _______________________ Conceptive Medication/Method? ______________

Number of pregnancies: ________ Number of Children: ________________

Age of first Pregnancy? _______ Age of last pregnancy? _______

AST MEDICAL HISTORY (check all that apply):

ıHeart attack	□Angina	□Liver Disease	□Sleep apnea
ıHigh blood pressure	□Stroke	□Gallbladder stones	□Thyroid
ıHigh cholesterol	□Diabetes	□Indigestion/reflux	□Anxiety
ıHigh triglycerides	□Gout	□Pancreatitis	□Depression
ıInfertility	□Arthritis	□PCOS	□Bipolar
ıGlaucoma	□Cancer (Type/s): ______		

'ast Surgical History: (List Surgeries you have had)

FAMILY HISTORY:

	Mother	Father	Sibling	Child	Aunt/Uncle
Addiction					
Alcohol Abuse					
Depression					
Thyroid problems					
Suicidal Idea or Plan					
Bipolar Disorder					
Heart Disease					
Alcoholism					
Anxiety					
Hight Blood Pressure					
High Triglycerides					
High Cholesterol					
Stroke					
Liver Disease					
Cancer: List Types					

HEALTH SCREEN

Have you been tested for HIV? ______YES _____ No If yes, When ______________________

What was the results of HIV Test? __________________

Have your been tested for Hepatitis C? _______YES _______NO

When were you last tested for Hepatitis C? ________________________

What were the results? ______________________

RELATIONSHIP HISTORY:

What is your current relationship status? ______________________

Describe your relationship ____

How many Children to you have? ______________

Describe your relationship with your children ____

List everyone who lives with you ____

Do you have a history of DUI? ____

Have you ever been incarcerated? ________YES ___________NO When? _______________________________

EMPLOYMENT HISTORY:

Are you currently employed? _______YES __________NO

What is your occupations? ____

Describe your current arrangements? ____

Eductions History (Highest Degree or grade level Acheived) ___________________________________

SYSTEM REVIEW (check all that apply)

- □Recent weigh loss more than 10 pounds
- □Recent weight gain more than 10 pounds
- □Acne
- □snoring
- □Difficulty breathing when flat
- □Swelling ankles/extremities
- □Constipation
- □Dysphasia/difficulty swallowing
- □Increased appetite
- □Gas and bloating
- □Nighttime Urination
- □Back pain (lower)
- □Dizziness
- □Weakness/low energy
- □Insomnia
- □Mood Changes
- □Cold intolerance
- □Heat intolerance
- □Skin rash
- □Bloating
- □Nausea/vomiting
- □Food intolerance
- □Heartburn
- □Slow urine flow
- □Back pain (upper)
- □Muscle aches/pain
- □Skin rash
- □Shortness of breath
- □Fainting/Blacking out
- □Abdominal pain
- □Diarrhea
- □Indigestion
- □Decreased appetite
- □Urinary Frequency/urgency
- □Blood in stools
- □Joint Pain
- □Headaches
- □Anxiety
- □Memory loss
- □Nervousness
- □Excessive sweating
- □Blood Clots
- □Cough
- □Chest Pain
- □Palpitations
- □Seizures
- □Depression
- □Inability to concentrate
- □Loss of interest
- □Hair changes
- □Fatigue/tiredness
- □Suicidal Ideas or Planning

COMMENTS:

How I Plan to Control my Opioid use ...

Goal setting is the "how" of controlling Opioid use. Motivators are the "why." When setting goals, utilize the **SMART** technique:

Example below

SMART	Technique	Example
Specific	Who, what, where, when how...	"I want to lose 10 pounds in two months."
Measurable	How will you track?	10 pounds in 8 weeks = 1.25 pounds/week
Attainable	Resources you have available, previous experience	"I have been able to do this before, and now I have new tools from me doctor!"
Relevant	Why this goal is important	Review your motivators
Timely	Set benchmarks and deadlines	"Focusing for two-month intervals works for me."

Please list three goals you would like to achieve during your treatment:

1._

2._

3.____

Why I Want to Control my Opioid Use...

Before you begin your Opioid management journey, it is important to spend time reflecting on why YOU want to take control of your Opioid use. Make sure that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

Please list five reasons you want to take control of Opioid use:

1._

2._

3._

4._

5._

Describe the physical benefits you hope to get by controlling your Opioid use:

Describe the functional benefits you hope to get by controlling your Opioid use:

Describe the medical benefits you hope to get by controlling your Opioid use:

Describe the psychological benefits you hope to get by controlling your Opioid use:

Comments:

New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

Preferred Pharmacy I understand I am only allowed to use ONE pharmacy by Paragon	☐ Yes ☐ No
Pharmacy Name	Pharmacy Location

Patient Information						
Name (First, Middle, Last)		Birth Date	Age	Social Security #		Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP				
Email Address		Primary Phone			☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No
Employer (or parent/guardian employer if patient is a minor)				Work Phone		
Primary Care Provider (where you go for your routine medical care)						
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer				

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Medicare Patient: Are you enrolled in Chronic Care Management with PCP?

Medicare Patient: Are you enrolled in Remote Patient Monitoring with any Physician?

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

Signature

Patient Name **Date:**

Consents	**Initital**
Consent For Treatment: I hereby consent to the treatment by the providers at Paragon Health Partners and its employees or designees. I auathorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.	
Consent for Medication History: I authorize Paragon Health Partners and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication History.	
Consent of Picture for Electronical Medical Record Chart: I understand and consent and authorize that my photo is taken for my Electronical medical record chart. If I am being treated for obesity medicine this picture will be attached to my progress note.	
Authorization for Release of personal health Information: I aurthorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applicationts ofr financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release clinical information related to my diagnosis and treatments for pain management, addiction medicine, alcohol or opioid, street drugs use, obesity medicine, which may be requested by my insurance or its designated agent.	
Assignment of Insurance Benefits/Payment Gurantee/Collection Fee: I authorize payment to be made directly to Paragon Health Partners, Paragon Primary Care, Paragon Pain & Rehabilitation, and/or any of its providers. For insurance payment payable to me. I understand that I am financially responsible to practice for any non-coverred servcies , as defined by my insurer. I understand that if my account balance becomes overdue if may be referred to collection agency. I understand payment is due at time of service.	
Privacy Policy: I acknowledge having received Paragon Health Partners, "Notice of Privacy Practices" My rights including the right to see a copy of my medical records, to limit disclosure of my health information, and to request an amendment to my record, is explained in the policy. I understand that I may revoke in writing my consent fo release of my healthcare information, excep to the extent Paragon Health Partners has already made disclosures with my prior consent.	
Disclaimer: By Typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this paperwork from Paragon Health Partners.	
Payment Policy All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.	
Late/No Show/Cancellation Fees: **Late is considered arriving for New Evaluation less than 30 minutes prior to appointment time. You can be rescheduled and will be charges a $50.00 Fee. Late for a Follow Up over 5 minutes will be rescheduled and charged a $25.00 Fee. A missed appointment, reschedule less than 48 hours prior will result in a $50.00 Fee, and a $25 fee if it is a follow up appointment . Telemedicine or Office Appointment.**	

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

Patient Name (Printed)

Responsible Party (Printed) (If patient is a minor or dependent adult)

Patient Signature Date

PARAGON
Health Partners

Medical Record Release of Information

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

____
Last First Middle

OTHER NAME(S) USED ______________________________

DATE OF BIRTH Month ________ Day ________ Year ________

ADDRESS ______________________________

____

CITY ______________ **STATE** ________ **ZIP** ________

PHONE (____)__________ **ALT. PHONE** (____)__________

EMAIL ADDRESS (Optional): ______________________________

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ________
Phone (______)______________ Fax (______)______________

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name:
PARAGON HEALTH PARTNERS/PARAGON PAIN & REHABILITATION
Address 2895 Lewis Lane Paris, TX 76034
Phone (972)-203-3600 Fax (972) 203-3601 Email: info@paragonphp.com

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ______________

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information**	☐ History/Physical Exam	☐ Past/Present Medications	☐ Lab Results
☐ Physician's Orders	☐ Patient Allergies	☐ Operation Reports	☐ Consultation Reports
☐ Progress Notes	☐ Discharge Summary	☐ Diagnostic Test Reports	☐ EKG/Cardiology Reports
☐ Pathology Reports	☐ Billing Information	☐ Radiology Reports & Images	☐ Other__________

Your initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)
______Drug, Alcohol, or Substance Abuse Records
______Genetic Information (including Genetic Test Results)
______ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ________ Day ________ Year ________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X______________________________ ______________
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): ______________________________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other ______________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X______________________________ ______________
Signature of Minor Individual **DATE**

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Personal Representative	Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed _____/_____/________

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

As a health care provider, we are committed to maintaining the privacy and confidentiality of your health information in accordance with Federal and State law and we are required by law to provide you with this Notice of Privacy Practices (Notice) that describes how health information that we maintain about you may be used or disclosed. This Notice also describes your rights and the obligations we have regarding the use and disclosure of health information. This Notice applies to Paragon Pain Rehabilitation LLP d/b/a Paragon Health Partners and Paragon Primary Care, PLLC d/b/a Paragon Health Partners, which are separate legal entities that are under common ownership and control and have thus organized themselves as a single Affiliated Covered Entity (Paragon) for purpose of compliance with the Health Insurance Portability and Accountability Act (HIPAA). This status permits Paragon to maintain a single Notice of Privacy Practices and to share health information as one organization as described in this Notice. Each of the Paragon entities will follow the terms of this notice.

Uses and Disclosures of Your Health Information

We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

Other Uses of Your Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Changes to this Notice.

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

Complaints

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint. **Privacy Officer**

For further information, please contact our Privacy Officer, Karen McNerney at: **POBox 1200 Colleyville, TX 76034 (972) 203-3600**

Patient Name:
Date:
Provider Name:
Telemedicine Site:

Informed Consent to Telemedicine Consultation

I have agreed to be seen for my appointment via a telemedicine consultation and or follow up visit with Paragon Health Partners, Paragon Pain & Rehabilitation, LLP and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation or follow up visit. I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult or follow up visit is done through a two-way video link-up whereby the physician or other health provider at Paragon Health Partners can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or video-conference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering. If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by Paragon Health Partners.
10. I understand this consent covers my intital evaluation and all follow up visit with providers at Paragon Health Partners.
11. If you are a resident of Oklahoma you are required to have an in person visit in the office before you follow up visits can be completed via telemedicine.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize Paragon Health Partners and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition. I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as “Agree” and I do not agree to any that I have initialed as “Decline.”

Date:______________________________ **Time:**______________ **AM/PM**

Signature: ____

Revised May 7, 2022