

**The PANS Center
PATIENT CONSENT FORM**

Patient Name: _____

Patient DoB: ____/____/____

Permission to Provide Treatment / Treatment Guidelines

I understand that all services provided for me by The PANS Center and its employees are voluntary and that I have an active role to play in my care and treatment. My treatment plan will be reviewed with me on a regular basis, and I may ask questions regarding my plan at any time. I understand that my record will be available within an electronic health record format.

My active role in my care and treatment child includes:

- Notifying our PANS Center provider(s) of all medical conditions, including ER treatment and pregnancy;
- Providing a complete and accurate history of patient and family medical history
- Providing complete information about current conditions in the household and among close contacts, including reporting known exposure to illnesses that may trigger PANS.
- Communicating fully and honestly with our provider(s) about the character and intensity of symptoms, the effect on our daily life, and how well the medicine or other treatment is helping to relieve them;
- Asking questions if I feel that I do not fully understand the treatment plan, including the alternatives and their relative risks and benefits.
- Storing medications and prescriptions in a secure, safe place, and otherwise preventing others from accessing the medications;
- Notifying your PANS Center provider(s) about all other medications and supplements (both prescription and over-the-counter) that your child takes, and of any changes in medications or supplements (starts taking, stops taking or changes dosages of);
- Being respectful and courteous to The PANS Center staff and other patients.
- Requesting prescription refills at least two business days before they are needed. Refill requests will only be reviewed during regular business hours, and are not reviewed during evenings or on weekends except in emergencies.

Privacy Policies and Release of Information

I have received and read the HIPAA Notice of Privacy Policies. I understand that all communication between my PANS Center clinician(s) and me is confidential; information about it cannot be released without my permission. The exceptions are: (1) if my clinician feels that I am in danger of hurting others or myself; (2) my clinician may discuss my treatment with other clinicians treating me including my PCP, other specialty providers or therapists; or (3) my clinician may discuss my case with other PANS Center clinicians for the purposes of improving the quality of care.

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I authorize The PANS Center to submit to my insurance company requests for prior authorization for tests or treatment and acknowledge that this means that The PANS Center will inform the insurance company or its agent of the proposed treatment, the diagnosis for which treatment is given, the dates and type of treatment, and diagnostic or treatment history if required.

Consent to Receive Telehealth Services

The PANS Center can deliver clinically appropriate assessment and treatment services to its clients via telehealth technologies, including the use of secure audio, video, electronic media, and/or other communications technology.

By signing and indicating my preference below, I consent to receive treatment via telehealth, in situations that are, in my clinician's professional judgment, appropriate for this modality of treatment. I understand that I am entitled to, and The PANS Center will ensure, the same rights to confidentiality and security as provided with face-to-face services, including those enumerated under HIPAA, 42 CFR Part 2 and other state and federal privacy laws; and I also understand that there may be some level of risk with respect to privacy when receiving telehealth services. I understand that I may decline telehealth services, and such choice will not impact my ability to continue receiving services from The PANS Center, including face-face services. I further understand that despite indicating my consent below, my clinician may determine that telehealth services are not appropriate.

Yes, I agree to receive telehealth services.

*Note: To receive telehealth services, consent to receive electronic communications will also need to be provided below.

No, I do NOT wish to receive telehealth services.

Consent to Receive Electronic Communications (Text Messages and Email)

By signing and indicating my consent below, I authorize The PANS Center to send me health-related notifications, such as, appointment reminders or telehealth access links, by regular, unencrypted text message and email. I do so with the understanding that: (a) the notification may contain my protected health information,¹ and (b) there is some level of risk that the message may be read by a third party.

I understand that I may refuse to sign this Consent and that my refusal to sign or receive health information via text message and/or email will not affect my ability to obtain treatment from The PANS Center.

Yes, I agree to receive health related information via regular text message/email.

No, I do NOT wish to receive health related information via regular text message/email.

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Patient Signature

Date

Witness Signature

Date

I understand that I may revoke any portion of this Consent in writing at any time, by contacting The PANS Center at 1-857-344-0820 or at admin@panscenter.org. I understand that the revocation will not affect any action taken by The PANS Center in reliance on this Consent before written notice of revocation is received by The PANS Center.

EFFECTIVE DATE: [3 /01/2024]

REVISION DATE: []

¹ As defined by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.