



301-330-0006

301-330-0444

info@alldaymedicalcare.com

AllDayMedicalCare.com

702 Russell Avenue, Suite 100  
Gaithersburg MD 20877

3915 Ferrara Drive  
Silver Spring, MD 20906

3508 Worthington Blvd, Suite 101  
Urbana, MD 21704

5525 Twin Knolls Road, Suite 323  
Columbia, MD 21045

## CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby give my informed consent for medical treatment at All Day Medical Care  
(Patients Name)  
Clinic. I understand and agree to the following terms and conditions regarding my treatment:

### Nature of Treatment:

I consent to receive medical and/or behavioral health care and treatment deemed necessary by the providers at All Day Medical Care Clinic. This includes, but is not limited to, diagnostic procedures, medical examinations, medications/medication management, laboratory studies and any other diagnostic and/or referrals made.

I also understand that at any time I can deny and/or refuse treatment being suggested by a provider at All Day Medical Care Clinic.

### Explanation of Treatment:

I have been provided with information about the nature of the proposed treatment, including its purpose, potential risks, benefits, and alternatives. All my questions and concerns have been addressed to my satisfaction.

### Risks and Benefits:

I understand that no medical and/or behavioral health care is without risks including suggested prescribed medications and I have been informed of the potential risks associated with the proposed treatment. I also understand the potential benefits of the treatment that are being suggested by the provider at All Day Medical Care Clinic.

### Tele-Health/Tele-Med/Tele-Therapy

- Nature of Telehealth Services:** I consent to receiving medical and/or behavioral health care through Tele-Health/Med/Therapy, which may include but is not limited to videoconferencing, telephone consultations, video recording and other electronic communications.
- Explanation of Telehealth Services:** I have been provided with information about the nature of the Tele-Health/Med/Therapy services, including how they will be delivered, the potential benefits, any potential risks, and the alternatives to Tele-Health/Med/Therapy services rather than seeing the provider face-to-face. But I understand this is always an open option to changing the type of service I am requesting.



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3. **Confidentiality:** I understand that my Tele-Health/Med/Therapy sessions will be private and confidential to the extent permitted by federal law under HIPPA guidelines. I acknowledge the potential risks of unauthorized access and agree to take necessary precautions on my end to ensure the confidentiality of the communication.
4. **Technology Requirements:** I am aware of the technology requirements for participating in Tele-Health/Med/Therapy services and confirm that I have access to the necessary equipment, internet connection, and software for effective communication is properly working. If I experience an issue, I will call the main office line at (301) 330-0006 to contact the provider.
5. **Emergency Situations:** In the event of a medical emergency during a Tele-Health/Med/Therapy session, I understand that I should call emergency services immediately. I authorize All Day Medical Care Clinic to contact emergency services on my behalf if necessary. At the start of each session, I will provide my location to the All Day Medical Care Clinic provider so they are aware of my location should I experience an emergency.
6. **Insurance Coverage:** I understand that insurance coverage for Tele-Health/Med/Therapy services may vary and that I am responsible for any associated costs. I will verify coverage with my insurance provider.
7. **Revocation of Consent:** I have the right to revoke this consent for Tele-Health/Med/Therapy services at any time. I understand that revoking this consent will not affect my right to future care or treatment.

### Emergency Situations:

In the event of a medical emergency where I am unable to communicate, I authorize All Day Medical Care Clinic to contact 911 emergency rescue, provide them with my current location and conduct CPR if necessary.

### Revocation of Consent:

I understand that I have the right to revoke this consent at any time, except to the extent that the provider has already taken action in reliance on this consent.

I have read and understood the above information, and I freely and voluntarily consent to the proposed medical and/or behavioral health care.

Printed Name of Patient: \_\_\_\_\_

Signature of Responsible/Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_