HUTTO WELLNESS, INC.
407 WALNUT STREET
GREEN COVE SPRINGS, FL 32043
904-863-3275, contact@huttowellness.com

Clinical Policies

PATIENT CONSENT FOR TREATMENT PAGE 1

Clinical Director: Daniel Hutto, **Autonomous Advanced Registered Nurse Practitioner**

Disclosure: in compliance with FL Satute 464.0123 (7)

64B9-4.001 Definitions. (12) Primary care practice – includes physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions.

64B9-4.021 Standards for Autonomous Practice. Advanced practice registered nurses who are registered pursuant to Section 464.0123, F.S., shall engage in autonomous practice only in a manner that meets the General Standard of Practice. The General Standard of Practice shall be that standard of practice, care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similarly situated, educated, and licensed Advanced Practice Registered Nurses.

Rulemaking Authority 464.0123 FS. Law Implemented 464.0123 FS. History–New 10-26-21.

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____Services must be paid for at the time of service.

_____Health insurance is not accepted at (HUTTO WELLNESS, INC.). If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company however there is no guarantee for insurance compliance.

_____If I am prescribed a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

_____I understand that treatments used at (HUTTO WELLNESS, INC.) might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through health restoration.

_____ I agree that if I am having any side effects or become sick, that I will notify (HUTTO WELLNESS, INC.) and/or go to an urgent care or emergency department.

_____I acknowledge that (HUTTO WELLNESS, INC.) and (DANIEL HUTTO, ARNP) would prefer to be your primary care provider. If you have another qualified provider for specific services, you are free to do so as your preference. I agree that I will continue with routine care through primary care services and notify any other medical service provider of treatments prescribed at (HUTTO WELLNESS, INC.).

PATIENT NAME: _____DATE OF BIRTH: _____

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PATIENT CONSENT FOR TREATMENT PAGE 2

_____I understand that there are no refunds for services or products rendered. We cannot re-use most supplies and medications once they have been opened or given per state regulation.

_____I understand that being seen at (HUTTO WELLNESS, INC.) does not necessarily entitle me to being issued a specific prescription or treatment. Every individual is different, and it is at the medical providers discretion to issue treatments and prescriptions.

_____I understand that I must maintain my follow up appointments to remain on routine treatments. It is important that lab work is monitored regularly for safety purposes. It is important that (DANIEL HUTTO, ARNP) manages my treatment and it is at their discretion to provide.

_____I agree to acknowledge that I will be advised of the risks and benefits of treatment. I also acknowledge that I will be advised of possible complications and side effects. I will understanding of the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with (HUTTO WELLNESS, INC.) and (DANIEL HUTTO, ARNP) regarding in office testing, send out testing, in office procedures, and additional treatment modalities as determined by a mutual decision between myself and the medical provider even if they are considered off label based off of other medical society recommendations and guidelines.

_____I do not hold any medical practitioner of (HUTTO WELLNESS, INC.) responsible for performing specialty testing other than baseline screening and or other age-related preventive care at my own discretion. I agree to referral to a specialist for any concerning findings that may require further testing. I agree that I will follow up for my primary care services at this clinic or other preferred provider to obtain these basic screenings and I hold (HUTTO WELLNESS, INC.) and (DANIEL HUTTO, ARNP) harmless if an adverse event occurs during my treatment. If I have any additional outside medical testing, I will ensure that any other medical provider provides the results such screenings to (HUTTO WELLNESS, INC.) as this could change the treatment prescribed to me.

I have read, understand and agree to all of the above statements.

Signature: _____Date:_____

PATIENT NAME: _____DATE OF BIRTH: _____