

Total Wellness Concepts LLC Consent for Treatment

I, _____, consent to participation in the Tobacco Free for Life smoking cessation program. I understand that tobacco cessation might involve continued risks in the course of treatment. I acknowledge that no guarantees have been made to me as a result of my treatment while in the Tobacco Free for Life program. I consent to allow a Tobacco Free for Life Nicotine Dependence Counselor to assist me with recommended programming. I also understand that Tobacco Free for Life uses the US Public Health Service /Mayo Clinic Model of nicotine replacement treatment. It might be suggested that I use a dosage of nicotine replacement that is greater than the manufacturers labeling, if I consume more than 20 cigarettes per day. I understand that recommended dosages will be based on medical clearance from my physician. In the event of any problems, I will immediately notify my physician and the Tobacco Free for Life counseling staff and follow their direction regarding the issue • I am responsible for any follow-up examinations with my physician that may be indicated from the results of this screening.

All reasonable steps will be taken by Total Wellness Concepts LLC to keep my name address and patient information confidential. I understand my personally identifiable health information will not be sold or given to any third party without express written consent by me. I also understand that the City of Columbus will only be provided with aggregate results and not individual confidential patient information. I understand that my patient information may be provided to my physician if I so request it in writing.

I hereby release Total Wellness Concepts LLC, and its associates, heir affiliates, companies, subsidiaries, directors, officers, employees, agents and contractors and any and all other organizations involved in the program, past or present officers, employees and agents and their successors from any liability and responsibility for any and all actions, causes of actions, individual and class action claims or demands of any kind what so ever, whether known, suspected or unknown in the law or equity including but not limited to, all claims or potential claims arising out of my voluntary participation, in injury, loss, or death arising as a result of this program.

By signing below, I acknowledge that I have read, understand and accept all of the statements on this consent form.

Patient Signature

Date

Patient Printed Name

Witness Signature

Date

Privacy Notice

I have received a “Notice of Privacy Practices” for protected health information.

_____ (Please initial)

(Revised 06/09/11)