1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3. **CONSENT TO RELEASE HEALTH INFORMATION:**
I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

4. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

6. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:**
I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location.
The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

7. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advanced health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision maker for health care decisions. By signing, you acknowledge awareness of these rights and understand the Physician Clinic can provide you with additional information and appropriate forms should you desire them.

8. **RESEARCH STUDIES:**
If you are currently participating in any research studies or clinical trials, we ask you please notify Registration and your Provider. You will be asked to provide a description of what is being studied (drug, medical device or other) and the Research Coordinator's contact information should your Provider have questions about the Study.

9. **CONSENT TO PHOTO/VIDEO:**
I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

10. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**
I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

11. **COMMUNICATIONS:**
I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

12. **VIDEOTAPING/RECORDING:**
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label