Patient Consent

Patient Name

Patient Date of Birth

Patient Address /City / State / ZIP Code

Parent or Legal Guardian Name

1. CONSENT TO MEDICAL CARE AND TREATMENT

The patient above is being treated at an IHA or St. Joe's Medical Group (SJMG) location, and I consent to all medical and surgical care, examinations and tests determined by the Physician to be necessary for the patient. I understand I have the right to decline services and testing, and I assume full responsibility and release IHA/SJMG relating to services and testing for which I decline. I do however, understand that financial assistance is available if I should need it. I know that the practice of medicine is not an exact science and outcomes may be different for each patient. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I assume full risk and responsibility and release the Physician Office and any individual Provider from responsibility for things that might go wrong if I do not seek and obtain the medical care and treatment recommended to me. I understand that I am being notified that if an exposure occurs, I may be tested for HIV/AIDS or other diseases as such notice being required by certain state laws.

Consent to Treat a Minor. I understand that I have an opportunity to have a third person representative act on my behalf regarding the treatment of my minor child (in my stead).

2. CONSENT TO USE OF INFORMATION

I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to the patient (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health and substance abuse, Pregnancy and Prenatal Care etc. The electronic health records (EHR) will be accessible by IHA/SJMG credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). As required by HIPAA, the Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of confidential medical information.

Use and Disclosure of Information: I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

I agree IHA/SJMG can share my information with past, future and current providers, caregivers and facilities to coordinate my health care, for payment and for administrative purposes, including quality and care management. This information may include dates and services provided, location where treatment was received, treatment information, names of doctors and health professionals, including mental health professionals, and any information related to diagnosis, hospital care, or treatment of my mental or emotional condition, except for substance abuse treatment provided in a federal Part 2 substance abuse unit. I understand that I have the right pursuant to HIPAA to request a restriction that could limit the information shared if IHA/SJMG agrees.

Consent to the Use of Telehealth. I understand that my medical information will be shared virtually and/or electronically. I understand there are potential risks to this technology. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.

Request for Information from Others. I consent to the Physician Office's request for my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in the EHR and any health information exchange, including the sharing of my information electronically. Please refer to the Physician Office's Notice of Privacy Practices for additional, detailed information regarding the uses and disclosures of protected health information.

3. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the Physician Office may use or disclose PHI for purposes of treatment, payment, or health care operations.

4. ASSIGNMENT OF BENEFITS

I assign to and authorize payment of all insurance and health care benefits available to the subscriber directly to IHA/SJMG for services provided to the patient. I understand that benefits may be payable to the subscriber directly if I do not provide this authorization.

5. AUTHORIZATION TO SHARE

I understand that I have an opportunity to authorize another individual to be involved in my care.

6. MISSED APPOINTMENT POLICY

I acknowledge that the office has a Missed Appointment Policy and that I may request the policy for review. I agree to notify the office as soon as possible if unable to keep the scheduled appointment time (not applicable for Urgent Care).

7. PERSONAL VALUABLES

I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

8. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer.

_____ _____

Signature of Patient or Patient's Legal Representative Date of Signature

_____

Print Legal Name of Signer

_____

Print Name of Patient's Legal Representative Relationship of Legal Representative to Patient
(e.g., parent, guardian, other, please explain)