# Financial and Consent for Treatment Authorization Form

Patient label

Patient: _____ Date of Birth: _____

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Center for Primary Care (CPC), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students and residents to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. TREATMENT OF MINOR CHILDREN: I understand minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for Chart identification and documentation purposes for my electronic health record and is the property CPC unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

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.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the CPC provider of service(s) furnished to me. I authorize CPC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to CPC. I hereby authorize that photocopies of this form to be valid as the original.

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I responsible for all charges occurred at time of service.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through CPC medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a CPC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with CPC's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by SwervePay, a third-party business associate. I hereby consent to have my payment information collected and stored securely by SwervePay.

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact CPC's staff if I am unable to pay your balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice. ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $35.00 NSF fee.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. CPC has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated CPC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. CPC and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). CPC will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

If I have provided my e-mail address, I am requesting the ability to access my medical information through the Center for Primary Care on-line Patient Portal.

ELECTRONIC PRESCRIBING: I understand that CPC medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my CPC providers and my pharmacy. I have been informed and understand that CPC 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 CPC providers to see this health information.

CONSENT FOR VIRTURAL 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.

IMMUNIZATION REGISTRY: I understand that CPC participates in the Georgia and South Carolina Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws. I do hereby grant permission for CPC to send or fax childhood immunization records to schools, upon request.

CELL PHONES: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the CPC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all CPC medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release CPC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a CPC medical practice, office or facility.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of CPC'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.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

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.

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| Signature of Patient or Parent/Legal Guardian/Authorized Representative | Relationship to Patient if Applicable |
| Witness to Signature | Date/Time of Signing |