1.Consent to Medical Care and Treatment

While being treated at Mount Carmel Medical Group ("Physician Office") I give consent for:

-all medical and surgical care

-tests and examinations needed

I expect my care to meet quality standards. I understand that there are no guarantees concerning the results of my care.

I understand that if an employee or any individual associated with the Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

I will not hold Physician Office or any person responsible for the results if:

-I refuse needed medical treatment

-Incur damages or injuries as a result of my non-compliance

I understand that I may be videotaped/audiotaped/photographed for performance improvement and/or quality/safety purposes. I understand that this will be stored in my permanent medical record.

2.Release of Information

I understand the Physician Office may use or release my health information for many reasons as

needed:

-insurance information

-billing and payment including release to other healthcare providers for billing and payment

-discharge planning and other health care providers

-quality improvement reviews

-Medicare, Medicaid, and other government programs

-Bureau of Workers' Compensation

-my employer if I am injured on the job

-medical and nursing education programs

-public health reporting

-legal, regulatory, and accreditation agencies

The Physician Office may receive or release my health information, whether written, verbal, fax, or electronic using secured internet web sites. The above also allows the Physician Office to release medical information about drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions. This authorization shall remain valid for one (1) year.

3.Acknowledgement of Notice of Privacy Practices

I have received or been offered a copy of the Physician Office's Notice of Privacy Practices. I have had a chance to object to the use or release of my information to the hospital directory or to my family or persons involved in my care.

4.Payment and Financial Responsibility

I hereby authorize and/or assign my Medicare or insurance benefits to be paid directly to the Physician Office. I realize I am responsible to pay non-covered services. I certify that the information given by me to the Physician Office, in applying for payment under Medicare or insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me to release to Medicare or the insurance company or its agents, any information needed to determine the benefits payable for related services. I consent to any request for review or appeal by the Physician Office to challenge a determination of benefits made by a third-party payer/insurer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Subject to applicable law and the terms and conditions of any applicable contract between the Physician Office and any third-party payer/insurer, and in consideration of all health care services rendered or about to be rendered to the patient named below, I agree to be financially responsible and obligated to pay the Physician Office for its billed charges not paid by a contracted insurance carrier or other third party payer/insurer.

5. Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. With this Authorization, you agree that we, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Health Information Management/Medical Records Department.

6. Communications

Subject to any limitations set forth by a separate document regarding disclosure of Patient's PHI, I agree that with respect to Patient's appointments, medical care, and payment for such care, the Physician Office, its assignees and designees, including third-party collection agents, is authorized to communicate with me through either a live person or an automated dialing system with artificial or pre-recorded voice, and through a variety of media including telephone calls, (both to my landline and wireless phone numbers), mail, emails, and text messaging, even when I may incur third-party service charges for such communications. I also hereby consent to leaving answering machine and voicemail messages for me, including messages regarding amounts owed by me and other information required by law, including debt collection laws.

7. Personal Items

The Physician Office is not responsible for any lost, stolen or damaged personal items. I am responsible for the items I choose to keep with me at Physician Office.

By signing below, I certify that I have read and agree to the contents of this consent and authorization document.

Name_____ Patient DOB_____

Patient Address / City / State / Zip Code_____

_____

Signature of Patient or Patient Representative_____ Date_____

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

_____ Date_____