

**General Consent for Care and Treatment Consent – Aspen Medical Group**

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
Employee Job Title

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
Date

## Patient HIPAA Acknowledgment and Consent Form

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

\_\_\_\_\_(Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice’s Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice’s Notice of Privacy Practices.

\_\_\_\_\_(Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**Disclosures to Friends and/or Family Members**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?”**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.**

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

\_\_\_\_ (Patient/Representative Initials) **I consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

\_\_\_\_ (Patient/Representative Initials) **I do not consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:**

**Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.** I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

\_\_\_\_ (Patient/Representative initials) **I consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

**The cell phone number that I authorize** to receive text messages for appointment reminders, feedback, and general health reminders/information is \_\_\_\_\_.

**The email that I authorize** to receive email messages for appointment reminders and general health reminders/feedback/information is \_\_\_\_\_.

**OR**

\_\_\_\_ (Patient/ Representative Initials) I decline to receive communication via text.

\_\_\_\_ (Patient/ Representative Initials) I decline to receive communication via email.

***If you have previously consented to receive communication via text/email and wish to remove the consent***

***Revocation (I do not consent to use my cell or email any longer)***

***I hereby revoke my request for future communications via email and/or text.***

*\_\_ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.*

*\_\_ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

*Patient Name:* \_\_\_\_\_

*Patient/Patient Representative Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_ *Time:* \_\_\_\_\_

**Prescription Order Pick-up.** There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

\_\_\_\_ (Patient/Representative Initials) I **wish** to designate the following individual to pick up a prescription order on my behalf:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_ (Patient/ Representative Initials) I **do not want** to designate anyone to pick-up my prescription order.

**Patient/Patient Representative Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name (Printed)** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Representative Name (Printed):** \_\_\_\_\_

## Telephone Messaging Consent

Frequently, someone at Aspen Medical Group will need to contact you by telephone regarding your health and/or your protected health information. In order to best protect your privacy, as well as provide excellent patient care, we ask that you complete the following consent. This provides us with specific direction as to where we may contact you regarding test results or specific information that you may want us to communicate to you.

I permit Aspen Medical Group to leave detailed phone messages at the following telephone numbers and/or with the following individuals. I agree that this consent will remain valid until revoked in writing by me or by an authorized designee (i.e., durable power of attorney)

Contact Numbers	May we leave a detailed message?	Preference (1, 2, or 3)
Home: _____	Y / N	_____
Work: _____	Y / N	_____
Cell: _____	Y / N	_____

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient (or Responsible Party) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS**

1. \_\_\_\_\_(Patient or Guardian Initials)

**Financial Agreement.**

- I acknowledge, that as a courtesy, Aspen Medical Group may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. \_\_\_\_\_(Patient or Guardian Initials)

**Third Party Collection.** I acknowledge that Aspen Medical Group may utilize the services of a third party business affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

3. \_\_\_\_\_(Patient or Guardian Initials)

**Assignment of Benefits.** I hereby assign to Aspen Medical Group any insurance or other third-party benefits available for health care services provided to me. I understand Aspen Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Aspen Medical Group, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. \_\_\_\_\_(Patient or Guardian Initials)

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Aspen Medical Group by the Medicare or Medicaid program.

5. \_\_\_\_\_(Patient or Guardian Initials)

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for Aspen Medical Group, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Aspen Medical Group or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Aspen Medical Group or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

**Patient/Patient Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are not the Patient, please identify your Relationship to the Patient (Circle or mark relationship(s) from list below):

Spouse      Guarantor      Parent      Legal Guardian      Healthcare Power of Attorney      Other: \_\_\_\_\_

## Your Patient Rights

Welcome to our Practice. We respect our patients' dignity and pride. This document will explain your patient rights and responsibilities. It is part of your patient registration and is an important part of your health care plan. If you have any questions, please contact the Practice/Clinic leadership.

Our commitment to you, our patient, includes the following rights. We affirm that we will **deliver high-quality health care to every patient without regard to: age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, health condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law**

## Considerate and Respectful Care

- Fair, high-quality, safe and professional care
- Care regardless of color, race, religion, creed, etc.
- Consideration, respect, and recognition of you and your individuality
- Treatment privacy
- Safe environment
- Ask for (except in emergencies) a person of the same sex to be available for any part of an exam, treatment or procedures performed by a person of the opposite sex
- Not be undressed any longer than needed for the exam, test, procedure, or other reason
- Private and discreet consultation, exam, and care. See Notice of Privacy Practices (NOPP) for the full list of privacy and security of health information/medical record rights
- To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with your treatment or diagnostic procedures

## Health Status and Care

- Be informed of your health status in terms and / or language that you, your family, and caregivers can be expected to understand
- Take part and be active in your care and treatment plan
- Participate in decisions in your care, unless your doctors or others believe it is harmful to you
- Know, be told, and understand:
  - the names, roles, and qualifications of your health care experts that provide your care
  - your follow-up care
  - risks, benefits and side effects of all medicines and treatment procedures for your diagnoses
  - innovative or experimental medicines and treatment procedures of diagnosis offered
  - alternative treatment options offered
  - your procedure and to “give informed consent” before it begins
  - possible outcomes of your care and treatment
  - the assessment and management of your pain
- When and if the Practice recommends other health care institutions:
  - to participate in your care
  - to know who these other health care places are and what they will do
  - to refuse their care
- Get help from the doctor and others for follow-up care, if available
- To change providers or get a second opinion, including specialists at your request and expense

## Decision Making and Notification

- Choose a person to be your health care representative or decision-maker
- Exclude those you do not want help from or to join in your care or decisions
- Ask for, but not have the right to demand, services the Practice does not think are needed or appropriate
- Refuse treatment

- Be included in experimental research only with your written consent
- Refuse experimental research including new drug and medical device investigations
- Receive the information necessary to approve a treatment or procedure
- Give consent to a procedure or treatment

#### **Access to Services**

- Receive translator, interpreter or other necessary services or devices to help you communicate with the Practice in a timely manner
- Bring a service animal except where prohibited pursuant to Practice policy
- Have access to our facility buildings and grounds in compliance with The Americans with Disabilities Act, a law that stops discrimination against people with disabilities. The ADA policy is available upon request
- Prompt and reasonable response to questions and requests for service

#### **Ethical Decision**

- Talk to and join in with your doctor about :
  - conflict resolutions
  - withholding resuscitative services
  - foregoing or withdrawing life sustaining care
  - investigational study or clinical trials
- Know that if your health care expert decides your refusal to accept treatment prevents you from getting the right care (as stated by its ethical and professional standards), it can end the relationship

#### **Protective Service**

- Receive available protective and advocacy services
- Be given the Practice's policies and procedures for:
  - Initiation, review, resolution of patient complaints, including the address and phone number to file complaints
- Discuss complaints, issues, or problems with your doctor and the Practice management team
- File a complaint with the Department of Health or others with your concerns about patient abuse, neglect, misuse of your property at the Practice, other unresolved complaints, patient safety, and quality concerns
- Have a fair review of alleged patient right violations
- Receive, as offered by state law:
  - care and treatment for mental illness or development disability
  - all legal and civil rights as a citizen
- Understand and expect emergency procedures without unneeded delay within Practice scope
- Get needed information to approve a treatment or procedure

#### **Payment and Administrative**

- Review your health care bill regardless of your ability to pay it or the payment source
- Receive information about available financial resources
- If uninsured, to receive, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding any discount or charity policies for which the uninsured person may be eligible.
- Know if the Practice, doctors and other team members accept Medicare, the government's health insurance for those aged 65+ or disabled
- Know and understand the Medicare charges for your services and treatment provided
- Receive if you ask, with explanation, a reasonable estimate of your health care charges before treatment
- To be free from any requirement to purchase drugs, or rent or purchase medical supplies or equipment from any particular source (specifically in accordance with the provisions of the CA Section 1320 of the Health and Safety Code) and also to receive patient choice in these type of decisions

## Your Patient Responsibilities

You are an important and active member of your care plan. You have certain responsibilities to yourself and to your care team.

In the spirit of shared trust and respect, we ask you to:

- Give true and complete information about your:
  - Health status
  - Medical history
  - Hospitalizations
  - Medicines
  - Other matters about your health
  - Contact information, family members and caregivers and other needed information
- Let us know:
  - any risks about your care
  - Changes in your care, illness, or injury
  - Safety concerns
  - Violation of your patient rights
  - If you understand your care plan and what we expect from you
  - If you don't understand your care plan or its information
  - If you have or need to ask questions
- Please:
  - Follow your care plan and instructions created by your doctor, nurses or other health care team members
  - Keep appointments and, if you cannot make your appointments, let us know at a minimum 24 hours before your appointment
  - Be responsible for your actions if you refuse care or don't follow doctor's orders
  - Pay your health care bills in a timely manner
  - Follow practice procedures, rules and regulations
  - Be thoughtful of the rights of other patients and our staff
  - Be respectful of yourself and our staff
  - Help staff to assess your pain, to assist you to discuss and get prompt relief, communicate your concerns about pain medicines and develop a pain management plan
  - Treat the doctor and our health care staff with respect and consideration
  - Accept that bad language or behavior is not tolerated and may be grounds for dismissal
  - Accept we may end our relationship if you do not follow your doctor's orders or care plan

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient (or Responsible Party) Signature: \_\_\_\_\_ Date: \_\_\_\_\_