**Patient Consent**

Definitions: “I,” “Me,” and “my” mean the patient. “Clinic” means Hallsville Medical Clinic, affiliated entities and employees. I am signing this agreement to obtain services.

If any part of this agreement is invalid, it will not affect the validity of the remainder of this agreement. Any invalid part will be deemed reformed to comply with the law. A photostatic copy of this form shall be as effective and valid as the original.

**Consent for Treatment**

I authorize the independent physicians, the Clinic, and all other persons caring for me to treat me in ways they judge are beneficial to me, including, medical and surgical treatment, and preventative care including immunizations. I authorize the Clinic’s employees to provide any and all necessary care during my treatment period to carry out all general and special orders of my independent physicians (including consultants, associates, and assistants of their choice.)

I understand and consent that I may receive care that is provided by a Physician Assistant (PA) or Nurse Practitioner (NP). I understand that an NP and PA or any medical professional that are Licensed Professionals who work within the Clinic under the supervision of my physician may discuss my care with my physician for treatment purposes.

**Authorization for Release and/or acquisition of information**

I hereby authorize the Clinic to release and/or acquire any necessary medical information to an/or from third parties including but not limited to other health care providers, any insurance company or third-party payor for the purpose of processing a claim, otherwise as allowed by law. I release the Clinic from any liability for the release and/or acquisition of this information.

**Consent for electronic sharing and health information exchange**

I hereby authorize the Clinic to release and send my medical information to my non-Clinic health care providers electronically and/or through a Health Information Exchange, an organization that provides services to enable the electronic sharing of health-related information. Medical information disclosed pursuant to this authorization may be used for treatment/payment/operational purposes. The medical information disclosed may become part of my non-Clinic health care providers’ medical records and may be re-disclosed by the recipient and no longer protected by state and federal privacy laws. I understand that I can change my mind and withdraw this authorization at any time by providing verbal or written notice to the Clinic’s Health Information Management (HIM) Department or the Business Office Administrator, but Clinic cannot take back information that has already been electronically shared. This consent is valid unless I have withdrawn it.

**HIPPA Notice of Privacy Practices**

The Clinic is required by federal and state law to maintain the privacy of your Protected Health Information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past present or future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. By initialing this section, you acknowledge that you have been given or offered a copy of the “Notice of Privacy Practices” of the Clinic.

I understand that I may change or revoke this form at any time by contacting the Health Information Management Department (directly forwarded to the Business Office Administrator) at the Hallsville Medical Clinic office location. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

**Patient Authorization**

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**Assignment of benefits**

I Certify that the information I gave in applying for payment of Medicare/Insurance Benefits is correct. I irrevocably assign and transfer to Clinic all Medicare and/or insurance benefits covering service for the payment of services rendered. I understand that it is my responsibility to comply with all pre-certification requirements and that I am responsible for any Health Insurance co-payments and deductibles.

**Financial Responsibility**

I understand that insurance coverage is not a guarantee of payment and I agree that I am **ultimately responsible for payment of services rendered** at Clinic. I will honor the payment policy. If I cannot pay in full at the time of service, the Clinic can ask others about my credit worthiness. I agree to pay all expenses related to collection, whether by collection agency or by an attorney. I understand that credit balances on my accounts may be transferred to and from Clinic to resolve balances past due. ARBITRATION: I agree to any controversy or claim arising out of or relating to Clinic charges shall be settled by arbitration administered under the Code of Ethics and Rules of Procedure for Mediation and Arbitration of the American Health Lawyer’s Association and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

**Automated Communications**

I consent to receive automated communications via electronic mail, text messages, and/or telephone calls on my cellular phone, other phone(s), and other communication devices, including, but not limited to autodialed calls, and pre-recorded, or artificial voice messages from the Hospital, its affiliates, successors, assigns, agents, servicers, and collection agencies. I understand these communications may be regarding appointment reminders or my financial responsibility for services provided to me. I understand these calls and messages may result in access fees from my cellular provider and I will be solely responsible for such fees. Consent may be revoked at any time by providing verbal or written notice to the Clinic Business Office Administrator.

**Outpatient Departments**

I understand that this facility is an outpatient department of the Hallsville Medical Clinic, and that I may receive two bills for the care I receive; one from the clinic for outpatient services provided at the Clinic and another from the physician for her/their/his services. I understand that my coinsurance payment responsibility depends on the amount of payment received and the plan details of my coverage.

**CLINIC CARE CONSENT**

1. **General Consent**: I consent to Hallsville Medical Clinic (“the Clinic”) giving me medical services and treatment that my doctor or other medical staff have ordered. My consent includes diagnostic testing (such as labs and x-rays) injections, medications, and other medical treatment. I have the right to make decisions about my care. I know that I have the right to discuss treatment and procedures with the doctor or PA beforehand. I also have the right to consent or refuse any treatment. Where appropriate, I consent to the delivery of care utilizing interactive video conferencing thereby enabling a provider at a distant location to provide treatment to me and/or consult and advise my local healthcare provider in making decisions about the care provided to me. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Clinic is under the direction of an independent provider who is not an employee of the Clinic. The Clinic is not responsible for the medical care, medical judgement, and plan of care provided by non-employees.
2. **PERSONAL PROPERTY**: I understand that I am responsible for my personal property while at the Clinic. The Clinic is not responsible for keeping my property safe.
3. **PATIENT RIGHTS AND ADVANCE DIRECTIVES**: The Clinic has provided me a copy of the Patient Rights and Responsibilities when I arrived to the clinic. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Clinic an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order. I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.
4. **FINANCIAL ASSISTANCE**: If I cannot afford my Clinic medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Clinic’s plain language summary of its Financial Assistance Policy. The full policy and more information packets are available at [www.hallsvillemedicialclinic.com](http://www.hallsvillemedicialclinic.com)
5. **RELEASE OF INFORMATION**: I allow the Clinic to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Clinic’s Notice of Privacy Practices. I agree that all records about my treatment are the Clinic’s property. I understand that medical records and billing information created or maintained by the Clinic are available to Clinic workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.
6. **MEDICARE/MEDICAID BENEFITS**: If applicable, I certify that the information given by me in applying for payment under Title XCIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.
7. **COMMUNICATIONS**: I authorize the Clinic (including any billing service, collection agency, agent, or contractor on the Clinic’s or contractor’s behalf) to contact me by phone at any number that I have provided to the Clinic at any time. The Clinic may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Clinic may use any pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Clinic may send me voicemail messages, text messages, or emails. I allow the Clinic to contact me using my email address that I have given, or any email addresses that the Clinic may obtain for me in the future.
8. **TESTING AFTER ACCIDENTAL EXPOSURE AND STATE REPORTING**: If a healthcare worker accidentally touches my blood or other bodily fluids, state law allows the Clinic to test me for certain diseases. These diseases include but are not limited to human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Clinic is required by law to report certain infectious diseases such as HIV and tuberculosis, to the state health department tor Center for Disease Control.
9. **DISCLOSURE OF OWNERSHIP**: I am aware that one or more doctors treating me at this Clinic may own or invest in a portion of the Clinic. I know I have the right to choose my healthcare provider. I choose this Clinic. I understand that if this Clinic meets the Medicare definition of a *physician-owned* *hospital* that the Clinic will give me a list of the owners if I ask for one.
10. **PHOTOGRAPHY**: I consent to the Clinic videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for medical education, quality improvement, research, or for other reasons related to treatment or operations. If the recordings or images are used, my identity will not be revealed. I will talk with my doctor if I do not want my recordings used for these purposes.
11. **ETHICS**: The Clinic may not be used for procedures that violated ethical directives as set by the doctors and owners.
12. **TEACHING AND OBSERVATION**: I understand that the Clinic may be a teaching facility. I consent to allow medical residents, students, and fellows who have a formal affiliation with the Clinic to participate in my care, as supervised by the treating physicians and permitted by Clinic policy. Students, residents, and fellows from other non-affiliated programs, as well as vendors may observe my care consistent with Clinic policy and as approved by my treating physician.
13. **NOTICE OF PRIVACY PRACTICES**: I have received a copy of the Clinic’s Notice of Privacy Practices at this or an earlier visit. The Clinic will give me a copy of the Notice of Privacy Practices any time I ask for one.
14. **FACILITY DIRECTORY**: Unless I object, the Clinic will include my name, location in the facility (room number or name) and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to the Clinic) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Clinic Directory.
15. **ASSIGNMENT OF BENEFITS:** In consideration of services rendered and to be rendered, the sufficiency of which is hereby acknowledged, I hereby **irrevocably assign and transfer** to Hallsville Medical Clinic (hereinafter referred to as the “Clinic”) all right title and interest in all claims or benefits payable for services rendered in the past or in the future, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person, or entity, (hereinafter referred to as “Benefits”) from whom my dependents or I may be entitled to recover. I further hereby irrevocably assign and transfer to the Clinic all right, title, and interest, in any and all causes of action against all insurance companies, employee benefit plans, liability carriers, third party administrators, tortfeasors, and/or all other persons or entities responsible for payment (hereinafter referred to as “Responsible Parties”) of benefits and I hereby appoint the Clinic as my attorney in fact with power of substitution to sue or otherwise obtain payment of benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of irrevocably granting the Clinic an independent right of recovery of Benefits against any Responsible parties, at its option, but shall not be construed to be an obligation of the Clinic to pursue any right of recovery. I hereby direct and irrevocably authorize all Responsible Parties to pay directly to the Clinic all Benefits and amounts due for services rendered by the Clinic without further request or written authorization from me. I further irrevocably authorize and direct that any Responsible Parties furnish copies of any Insurance policies, employee benefit plans, or any other document requested by the Clinic without further request or written authorization from me. I understand that in the event that the Clinic is not paid in full by proceeds of my insurance policies, this assignment does not release my obligation and liability to the Clinic for payment of services and items provided to me by the Clinic. I agree to pay the Clinic for all charges incurred by me, or in the alternative, for all charges in excess of the sums actually paid by my Insurance policies. We have the right to apply available funds in any or all of your accounts with us and our affiliates otherwise payable to you to any prior existing or future debt that you owe us. When we set-off a debt that you owe us, we reduce the funds in your account(s) by the amount of the debt. We are not required to give you any prior notice to exercise our right of set-off. The effect and consequences of this irrevocable assignment and financial responsibilities have bene fully explained to me to my understanding and I have signed this document freely and without inducement.
16. **INSURANCE NETWORK:** Based on the information currently available, Clinic staff have advised me if my primary health insurance plan is out of network; The Clinic will submit a claim to my insurance plan, but my insurance plan may limit its coverage to something less than the full cost of care. I may be billed additional amounts by the Clinic. I may also have higher out-of-pocket costs. I should contact my insurance provider for additional information.
17. **BALANCE BILLING DISCLOSURES**: Health care services may be provided at a network health care facility by facility-based physicians who are not in my health plan. I may be responsible for all or part of the fees for those out-of-network services in addition to applicable amounts due for co-payments, co-insurance, deductibles, and non-covered services. I can find specific information about in-network and out-of-network facility-based physicians at my health plan’s website or by calling the customer service telephone number of my health plan.