General Consent for Treatment and Payment Authorization

Consent for Services

I request and authorize **MD2U's** Providers and other MD2U personnel according to the Provider's instructions, to provide medical care and services to me that may include, but is not limited to, diagnostic, radiology and laboratory procedures, and medication administration. I understand that consent is being given in advance of any specific diagnosis and/or treatment and intend this consent to be continuing in nature even after a specific diagnosis has been made and/or a treatment recommended. I authorize MD2U to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee or promises have been made to me with respect to results of such diagnostic procedures or treatment.

I understand and agree that samples of body fluids and/or tissues may be withdrawn from me during diagnostic procedures. I authorize MD2U to dispose of the body fluids.

I may be asked to consent to testing for HIV (human immunodeficiency virus-AIDS) and Hepatitis if a health professional or MD2U employee or First Responder sustains an exposure to my blood or other body fluids.

I have been informed that MD2U may permit students, externals, or potential employees to attend my medical examination. I further understand that these individuals may be exposed to my confidential medical information. I consent to these individuals' presence during my treatment.

Assignment of Insurance Benefits and Payment Authorization

I understand that MD2U provides primary care medical services on a fee-for-service basis. As a courtesy to me, MD2U will file a claim for payment from my insurance carrier. I authorize and instruct my insurance carrier to make payment directly to MD2U. I also understand and agree that I am personally responsible for all charges that are not covered by or collected from any insurance program, including deductibles and co-insurance amounts.

Patient Photography Release

I give permission to MD2U to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate science papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

Additional Services – Chronic Care Management (CCM)

My Provider has discussed with me how CCM is a service designed to help me manage my overall health care needs. I understand there is a cost for this service and that my insurance may or may not cover it. If I agree to use this service, I understand that I may be responsible for up to 100% of the cost of this service.

Chronic Care Management (CCM) – I acknowledge that my Provider explained to me CCM and that if I accept the service I may be responsible for all or a portion of the cost associated with this service.

☐ Accept. I want the Chronic Care Management service. ☐ Decline. I do not want this service.

Additional Services – Care Plan Oversight (CPO)

My Provider has informed me that MD2U will provide and charge for the Care Plan Oversight (CPO) service as a part of coordinating my home health services, if and when I should need them. I understand that I will be responsible for any cost of this service not covered by my insurance, including any co-pays and/or deductibles.

HIPAA

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that MD2U give me a Notice of Privacy Practices that describes how MD2U will use and disclose my protected health information and explains my individual rights.

☐ I have received a copy of MD2U's Notice of Privacy Practices. I understand that a copy of the current Notice of Privacy Practices is posted on MD2U's website at: http://md2u.com. I further understand that MD2U reserves the right to change its notice and practices and will post the revised notice on its website. I can receive a copy of the most current notice at any time by requesting one be mailed to me.
☐ Patient unable to acknowledge receipt of the Notice of Privacy
☐ Patient refused to Sign Acknowledgement (reason):____

Confidential means of communication

HIPAA gives you the right to ask us to communicate with you in a different way such as sending information through the mail in an envelope instead of a post card, sending information to a different mailing address than my home address, and calling a phone number different from my home phone, or by using only email to communicate with you. MD2U will agree to your request if it is reasonable but reserves the right to contact you at any address or means available if necessary for treatment and/or for health and safety reasons.

☐ Yes ☐ No I have a request for a confidential way of communicating: ________________________________

☐ Yes ☐ No Leaving messages on my answering machine. Unless you object, we may leave messages about appointment reminders, simple changes in medication and/or results of lab tests on your answering machine (and on phone voice mail). MD2U is committed to safeguarding your protected health information and will take reasonable steps to limit the amount of information disclosed in this manner.

☐ Yes ☐ No Email – Communicate by unencrypted emails. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information. We will encrypt email communications to you unless you tell us not to. Communicating by unencrypted email increases the possibility that the confidentiality of the email could be breached by a third party. If you wish to communicate through unencrypted emails, you must acknowledge and consent to the following conditions:

- Without encryption, an email containing your protected health information is considered unsecured and has a greater chance of being read by an unauthorized individual. Although it is unsecured, MD2U will continue to apply other means to safeguard the confidentiality of the information within an email such as limiting the amount of information included in the email, checking the email address for accuracy, and including a confidentiality statement on the email.
- Email is not appropriate for urgent or emergency situations nor can MD2U cannot guarantee that any particular email will be read and responded to within any particular period of time.
- If you are waiting on a response and do not receive one within two (2) business days, it is your responsibility to follow-up to determine whether the intended recipient received the email and when the recipient will respond.
- Email must be concise and should not contain sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. If the issue is too complex or sensitive to discuss by email, you should request an appointment instead.
- Emails will usually be printed and filed in your medical record.

<u>Release of Information to Those who May be Involved in My Care</u>

The following individuals may be involved in my care. MD2U has my permission to discuss/disclose PHI to them on my behalf.

Name		Relationship	Contact Information (Phone)
1.			
2.			
3.			
4.			

OR

☐ Contacts listed in my Demographics have been reviewed with me and are correct.

These individuals may (please check all that are applicable):

☐ Make/verify appointments
☐ Discuss financial information
☐ Discuss treatment options
☐ Receive messages
☐ Pick up requested information/records
☐ Request (on my behalf) a copy of my medical record be sent to my home address

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Signatures: By signing, I acknowledge that:

1. I have read or had read to me, and fully understand this consent and I have had the opportunity to ask questions, have the questions addressed, and make a decision about Chronic Care Management.

2. I understand MD2U may request from and/or disclose to other medical providers my protected health information for treatment, payment or healthcare operations.

3. I have authorized the disclosure of information to the individuals listed above.

Patient Name: ____ Date: ________________________

Patient's Representative: _____________________________________ Relationship: __________________

Signature of Patient/Patient's Representative: ____