# AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize **AchyJoint**, its medical practices and providers including physicians, surgeons, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I understand the explanation(s) given and I acknowledge that no guarantee can be given to me by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Insurance Portability and Accountability Act.

INSURANCE DISCLAIMER: Patient represents and warrants AchyJoint Services to be provided pursuant to this Agreement are not covered under any public or private health insurance program. Notwithstanding the above, Patient understands and agrees to be wholly responsible for the payment of any and all costs due and that may become due pursuant to this Agreement, regardless of the existence of coverage for such items or services under any public or private health insurance program. Patient understands and agrees not to submit a claim, bill to or seek reimbursement from any public health program (i.e. Medicare, Medicaid, Tricare, Veterans Affairs and Federal Benefits) or any private health insurance plan or worker's compensation plan for any item or service received pursuant to this Agreement. Patient understands that he or she will not be able to appeal any determinations that public health program, private health insurance plan, or worker's compensation plan will not pay for any item or service received pursuant to this Agreement. I hereby authorize the photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through **AchyJoint medical practices** and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an **AchyJoint** 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 **AchyJoint's** approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: I have been made aware and understand that the medical practices and offices within **AchyJoint** may use an Electronic Health Record. **AchyJoint** medical practices and providers may share my health information to serve my medical needs. I further understand that my protected health information will remain secure as required by law.

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

IMMUNIZATION REGISTRY: I understand that **AchyJoint** participates in the Pennsylvania 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.

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

PERMISSION TO FAX IMMUNIZATION RECORD: I do hereby grant permission for **AchyJoint** to send or fax immunization records to work, schools, or any health care facility, upon request.

I, or my legal representative, certify that I have read this document in entirety, 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.

_____ _____

Name of Patient & Date of Birth

Or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

_____ _____

Signature of Patient

Or Parent/Legal Guardian/Authorized Representative

Date of Signing

# Telemedicine Informed Consent

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used 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 and to ensure its integrity against intentional or unintentional corruption.

Responsibility for the patient care should remain with the patient's local clinician, if you have one, as does the patient's medical record.

**Expected Benefits:**

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this agreement, You acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

**Patient Consent:**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent to participate in a telemedicine visit under the terms described herein. I acknowledge receipt of the Health Insurance Portability and Accountability Act.

I, or my legal representative, certify that I have read this document in entirety, 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.

_____ _____

Name of Patient & Date of Birth Relationship to Patient if Applicable

Or Parent/Legal Guardian/Authorized Representative

_____ _____

Signature of Patient Date of Signing

Or Parent/Legal Guardian/Authorized Representative