Patient Consent

1.Use and Disclosure of Protected Health Information
I hereby give my consent for [SOS Mobile Medical Care] (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).
With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

2. Notices of Privacy Practices:
Required pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I acknowledge that I have received a copy of the Clinics Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Practice. Including but not limited to treatment for mental health, drug, and alcohol abuse, communicable disease such as HIV/AIDS. Developmental disabilities, genetic testing and other types of treatment received.

3. General Consent for tests, treatments and services,
I have been informed of the treatment procedures considered necessary for me and that the treatments procedures will be directed by a Physician or Advanced Practitioner in accordance with state laws scope of practice and licensure.

4. Patient Consent for E-Prescribing (Electronic Prescribing)
I have been made aware and understand that the medical practice and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my 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 providrs to see this protected health information.

5. Consent for virtual, health/telemedicine services
I hereby consent to engaging in virtual health or telemedicine services, where available as part of my treatment. I understand that “virtual health”or “telemedicine services” includes the practice of healthcare delivery diagnosis, consultation, treatment, transfer of medical data, and education using interactive, audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network

software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with the information transmittal, including but not limited to poor data transfer which may include a poor video and data quality, experience or lack of access to my complete medical record by the remote provider. I understand that all information including images will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

6. Advance directive acknowledgement:
Federal law requires that patients be provided information about their rights to make advanced health care decision, including a living will, durable medical power of attorney or designation of a surrogate decision maker for health care decisions By signing your acknowledge awareness of these rights and understand the Practice can provide you with additional information and appropriate forms should you desire them.

7. Research Studies:
If you are currently participating in any research studies or clinical trials, we ask you please notify your provider. You will be asked to provide a descrip-tion of what is being studied and obtain the research coordinators contact information should your provider have questions about the study.

8. Consent to Photo/video:
I consent to the photographing, videotaping and/or video monitoring including appropriate portions of my body for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

9. Consent to photograph at the time of Registration:
I, or my authorized legal representative hereby give consent to the medical practice to take my photograph at the time of registration, I understand this photograph will be stored in the medical practice ambulatory medical record electronically as my photo identification.
I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

10. Communications:
I consent to this facility, its successors or assignees contacting me via the methods I provide to the facility. I understand the communications may occur in any manner including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone or email messages. I understand the communications may be about any matter including but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure and I assume the risks of transmitting health information via unsecured means, If I incur any cost from being contacted at the telephone numbers or email address provided to the facility including but not limited to data, roaming, text messages additional minutes or other fees, I understand that the Practice is no responsible for paying these charges This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the practice.

11. Videotaping and Recording:
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.