CONSENT FORM- XXX Office Visit

Patient was offered and accepted the use of an Employed Language Interpreter or Contracted Interpreter Service:

- In Person: _____(Interpreter's Name)
- Phone: _____(Interpreter's First Name and ID Number)

Patient was offered and declined the use of an Employed Language Interpreter or Contracted Interpreter Service:

- Name of Interpreter: _____Relationship/phone number: _____

PLEASE READ CAREFULLY AND SIGN THE NECESSARY AUTHORIZATION, RELEASES AND AGREEMENTS SO THAT [*Name of Physician Office]* (THE "PHYSICIAN OFFICE") MAY PROCEED W I T H YOUR CARE AND TREATMENT.

1. **CONSENT TO PHYSICIAN OFFICE SERVICES:** I hereby consent to the rendering of care, which may include diagnostic procedures and medical treatment as my physician(s) prescribes. I understand that my care team at the Physician Officemay include resident physicians and students or other trainees. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me as the result of examination or treatment.

2. **RELEASE OF INFORMATION:** To obtain payment for services, I hereby authorize the Physician Office and/or any physician or other provider providing services to disclose to my insurance carrier copies of my medical record relating to my office visit hereunder. I recognize that the information disclosed may be information that is protected by federal and state law and specifically consent to disclosure of such information.

3. **ASSIGNMENT OF BENEFITS**: I hereby assign to the Physician Office and/or any physician providing medical services while I am a patient of the Physician Office, all physician practice and medical benefits payable to me for my benefit for my treatment. I grant permission and consent to the Physician Office, its assignees and third party collection agents (1) to contact me by phone at any number I have provided including wireless cell numbers (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any phone numbers and email addresses I provide and (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto- dialer) in connection with any communications made to me or any related scheduled services and my account.

4. **FINANCIAL AGREEMENT:** The undersigned, in consideration of the services to be rendered to the patient, acknowledges the obligation to pay the Physician Office in accordance with its regular rates and terms and the requirements of the undersigned's health benefit plans, and, if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees and collection expenses. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay the physician office may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
   In furtherance of the right to recover payment for services rendered to me, I agree to allow the Physician Office to file any appeals of denials or take any other action deemed appropriate by them on my behalf, including, but not limited to, signing my name on necessary documentation, to seek recovery of full payment from any third party payors or other responsible entity for medical care rendered to me, or to seek recovery of replacement product from any p harmaceutical or medical device manufacturer patient assistance program.

5. **FOR MEDICARE PATIENTS:** I have read the above and fully understand its content. I certify that any information given by me applying for payment under Title XVIII of the Social Security Act is *correct.*

6. **I PATIENT PRIVACY PRACTICES NOTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices of Thomas Jefferson University (TJU), including the clinical operations referred to as Jefferson Health, which includes the Physician Office.**

7. **USE OF IMAGES:** I hereby authorize representatives from the Physician Office to videotape and/or photograph portions of my body for purposes of assessment and evaluation of certain conditions and internal clinical and educational purposes. As part of my medical care and treatment, I consent to the use of video monitoring, as deemed appropriate by my health care providers, as a means of promoting and maintaining my personal safety. I understand that video monitoring is live stream only and will not be recorded or distrib uted. I also consent to examination and treatment via two-way interactive audio and video communications (i.e., telemedicine) when appropriate. I understand that my participation in telemedicine is voluntary and I may request in-person services at any time. The undersigned certifies that he/she has read the above and is the patient, parent, guardian, or representative authorized to execute the above and accept its terms.

Signature of Patient

Signature of Person Authorized to Consent for Patient

Relationship to Patient

Signature If the patient is unable to sign upon arrival, state the reason and initial

Signature of Witness

Time

Date

CONSENT FOR PHYSICIAN PRACTICE SERVICES

FORM 203834 (01/19)

Patient Name _____
Please Print

Date of Birth _____
mm/dd/yyyy

Medical Record No _____