CONSENT TO TREATMENT AND ADMINISTRATIVE AUTHORIZATIONS

1. **Authorization for Treatment and Diagnostic Procedures:**

I voluntarily authorize, request and consent to inpatient/outpatient care and services, including diagnostic tests, procedures, examinations and medical treatments as ordered by my physician, his/her assistants, designees or other health care providers. I understand that the treatment ordered may require use of a range of medical devices and equipment, including but not limited to, intravenous (IV) lines, urinary catheters and others. This consent extends and applies to Bryn Mawr Personalized Primary Care PC (BMPPC). I understand that except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I also authorize BMPPC to deliver telemedicine health care services to me and understand this involves the use of interactive telecommunication technology to facilitate the assessment, diagnosis, monitoring, consultation, treatment, education, care management and/or self-management of health care while I am at the originating site and the health care provider is at a distant site, which may include, but is not limited to, sending digital radiology or other diagnostic images to an off-site radiologist or other specialist and/or non-recorded two way video for health care providers, including psychiatrists and other specialists, to render care to me. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

2. **Release of Information (Including Medical Record Information):**

I authorize BMPPCto furnish protected health information (PHI), demographic and other information about me maintained by BMPPC. I authorize BMPPC tto furnish PHI, demographic, and other information from my medical record, as well as other information about me such as billing records, to my insurance company, third party payors, accountable care organizations, case utilization and managed care review organizations, including past or present employer(s) in the case of Workers' Compensation. I further authorize PHI, demographic, and other information from my medical record to be released to any health care provider, pharmacy, or institution providing health care, pharmacy or social services to me. Consent is also given for release of information to BMPPC by any insurer and all other agencies, pharmacies, institutions, or individuals from whom I have received or will receive medical, pharmacy or social services.

3. **Patient Rights:**

The Patient Rights and Responsibilities brochure is available on the BMPPC website at brynmawrppc.com and visible in the office,

I have been informed of those rights prior to my treatment.

4. **Health Information Exchange:**

A health information exchange (HIE) is a network that allows participating healthcare providers and their billing companies, insurers, health plans, and accountable care organizations to share electronically patient PHI for treatment, payment, health care operations purposes and other lawful purposes as permitted by law. HIEs make it possible for BMPPC to electronically share patients' PHI to coordinate their care, obtain billing information and participate in quality improvement activities, among other things (Permitted Purposes). I understand that sensitive information such as mental health, drug and alcohol treatment, HIV-AIDS status and sexually transmitted diseases may be contained in certain documents accessed through the HIEs and I consent to this.

5. **Authorization to Pursue Grievances:**

I authorize BMPPCto file grievances with any insurance company, third party payors, case utilization and managed care review organizations which may be necessary to challenge denials of authorization or payment for a health care service. I understand that any medical care I receive is not premised on this authorization to file grievances and I understand that I may revoke this authorization allowing BMPPC to pursue grievances on my behalf at any time during the grievance process, by providing written notice toBMPPC. Finally, I understand that if BMPPC files a grievance to challenge denials

of authorizations or payment for health care services on my behalf, I will not be able to file a separate grievance on the same grounds.

6. **Assignment of Insurance Benefits to BMPPC/Financial Agreement:**

I authorize payment of health care benefits directly to BMPPC. I understand and agree that I may be financially responsible to BMPPC for charges not paid under my insurance policy(ies or covered as part of my membership plan.

7. Assignment of Insurance Benefits to Physicians:

I request that payment of authorized Medicare or other payor benefits be made either to me, or on my behalf, to the physician or supplier for any services furnished to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

8. Authorization to Contact:

I authorize BMPPCto contact me about my care, appointment reminders, accounts, informational communications about health related programs and services, and for debt collection purposes. Ways that I authorize BMPPC to contact me are the following: direct mail, electronic mail, telephone, cell telephone (voice or text), including voicemail messages and through the Spruce App messaging system. BMPPC may use any of the telephone/cell phone numbers, email addresses and mailing addresses contained in my medical record. I understand that these contacts, communications, messages and text messages may include my PHI and other health related information about me. I understand that there may be some level of risk that information in an unencrypted electronic transmission could be read by a third party and I accept this risk. I understand that if the telephone number is a cell phone number, I may be charged for such calls or texts by my wireless service provider. I permit a copy of this authorization to be used in place of the original.

9. Advance Directives:

I have a Living Will **(Required)**

YesNo

If yes, was copy provided? Yes No

I have a Health Care Power of Attorney **(Required)**

YesNo

If yes, was copy provided? Yes No

10. Claims:

I agree that if I bring a claim or legal action of any kind that relates to my care or the medical services provided by BMPPC, I will file those claims or actions only in the Commonwealth of Pennsylvania , Court of Common Pleas of: Delaware County.

12. Photo Consent:

I authorize BMPPC to take or record photographs, video/audiotapes, digital or other images of me for the purposes of treatment, identification, quality improvement and education within the institution, and documentation of my medical condition or course of treatment in the medical record. I am also aware that in certain clinical areas, video monitoring may be utilized. I understand that in all instances patient confidentiality will be preserved.

I hereby certify that I have read and fully understand the above consent. I have had sufficient opportunity to ask whatever questions I might have and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its terms.

(Required)

By clicking this box I understand and acknowledge that I am signing this document electronically."

Relationship to Patient

self **(Required)**

Signature of Patient or Authorized Representative