KATY
4521 HWY 6 N.
HOUSTON, TX 77084

SOUTHWEST
8783 S. GESSNER RD
HOUSTON, TX 77074

NORTH
349 W. GREENS RD
HOUSTON, TX 77067

PASADENA
3512 FAIRMONT PKWY
PASADENA, TX 77504

Houston Medical Group

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1. Personal & Contact Information

Type of Visit	☐ Auto Accident ☐ Work Injury ☐Private Health Current Date: _____/_____/_____
First Name	_____ Last Name: _____
Gender	_____ Social Security Number: _____ - _____ - _____
Address	_____City_____State_____Zip_____
Date of Birth	_____/_____/_____ Home #: _____ Cell #: _____
Race Ethnicity	☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Island ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Decline to disclose ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Mexican, Mexican American or Chicano ☐ Cuban ☐ Unknown
Next of Kin	Name: _____ Ph: _____
Employer	_____ Work Ph: _____ Occupation: _____
Work Address	_____ City _____ State _____ Zip _____
Emergency Contact Name	_____ Relationship _____ Ph: _____

2. Insurance & Legal Information

Health Insurance

Primary Insurance	_____ID #: _____Group #:_____
Address	_____ City/State/Zip: _____
Phone	_____ Primary Ins. Contact/Adjuster: _____
Policyholder Name:	_____ Policyholder DOB: _____
Relationship to Patient	☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Auto Accident Insurance (if applicable)

Date of Accident	_____/_____/_____State Accident Occurred In: _____
Insurance Company	_____ Claim #: _____
Adjuster Name	_____ Adjuster Phone/Email: _____
Attorney Involved?	☐ Yes ☐ No If yes: Name: _____ Phone: _____

3. Accident & Injury Details (if applicable)

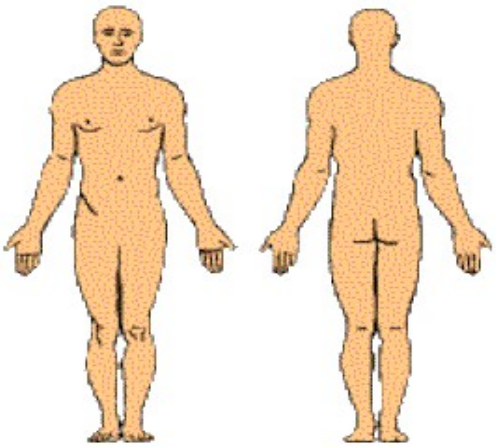
Question	Response
Were you the:	☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian
Type of Collision:	☐ Rear-ended ☐ Side-impact ☐ Head-on ☐ Rollover ☐ Other _____
What types of other vehicles were involved?	_____
What kind of vehicle were you in?	_____
Vehicle Damage:	☐ Minor ☐ Moderate ☐ Severe ☐ Totaled
Seatbelt Worn?	☐ Yes ☐ No
Airbags Deployed?	☐ Yes ☐ No
Loss of Consciousness?	☐ Yes ☐ No
Initial Treatment?	☐ None ☐ ER ☐ Urgent Care ☐ Primary Doctor If yes, name of facility: _____
Transportation from Scene:	☐ Ambulance ☐ Drove Self ☐ Other: _____

4. Main Complaint / Present Symptoms

What is your main complaint?_____

Pain Description (Check all that apply)
☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Throbbing ☐ Shooting
Pain Triggers
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Driving ☐ Walking ☐ Lying down ☐ Stress
Pain Relief Methods
☐ Ice ☐ Heat ☐ Medication ☐ Rest ☐ Movement ☐ Other: _____

Mark Areas of Pain on Diagram



____ Neck/Cuello ____ Between Shoulders/Entre hombros
____ Low Back/Espalda Bajo ____ Headaches/ Dolor de Cabeza
____ Stomach/Estomago ____ Chest/Pecho
____ Shoulder/Hombro ____ R/Derecho ____ L/Izquierda
____ Arm/Brazo ____ R/Derecho ____ L/Izquierda
____ Elbow/Codo ____ R/Derecho ____ L/Izquierda
____ Wrist/Muñeca ____ R/Derecho ____ L/Izquierda
____ Hand/Mano ____ R/Derecho ____ L/Izquierda
____ Finger/Dedos de Mano ____ R/Derecho ____ L/Izquierda
____ Hip/Cadera ____ R/Derecho ____ L/Izquierda
____ Leg/Pierna ____ R/Derecho ____ L/Izquierda
____ Knee/Rodilla ____ R/Derecho ____ L/Izquierda
____ Ankle/Tobillo ____ R/Derecho ____ L/Izquierda
____ Foot/Pie ____ R/Derecho ____ L/Izquierda
____ Toes/Dedos de Pie ____ R/Derecho ____ L/Izquierda

5. Medical History

Have you gone to a chiropractor before? ☐ **Yes** ☐ **No**

Have You Ever Had The Following: (check all that apply)

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Seizures ☐ Allergy ☐ Asthma
☐ Diabetes ☐ Cancer ☐ Arthritis ☐ Osteoporosis ☐ Anxiety / Depression ☐ Fainting
☐ Spinal Surgery ☐ Broken Bones ☐ Head Injuries ☐ Autoimmune Disorders
☐ Other: _____

Current Medications (include over the counter medicine):

_____

Allergies (medications, food, etc.):

_____

Surgeries / Hospitalizations (with dates):

_____

6. Lifestyle Information

Activity	**Frequency/Notes**
Tobacco Use	☐ Yes ☐ No — If yes: _____
Alcohol Use	☐ Yes ☐ No — If yes: _____
Caffeine	☐ Yes ☐ No — If yes: _____
Recreational Drugs	☐ Yes ☐ No — If yes: _____

7. Functional & Work Limitations

- Are you currently working? ☐ Yes ☐ No
  If no, why not? _____
- Has this injury affected your ability to:
  ☐ Perform job duties ☐ Sleep ☐ Drive ☐ Perform household tasks
- Have you missed work due to this condition? ☐ Yes ☐ No
  If yes, how many days? _____

If patient is a minor, name/address of person responsible for care:_____
I give permission for this minor to be seen at this office

Patient Signature:_____ Date: _____

ATTESTATION

By my signature below, I hereby attest and certify that the personal injury claim that I am pursuing was the result of the legitimate accident that occurred on the day of _____/_____/_____.

I hereby acknowledge that I have been informed by Houston Medical Group that it is a violation of federal and State Law to falsely claim that I was injured or involved in an accident that is in any way staged or set up for the purpose of filing a fraudulent claim.

Further by my signature below, I acknowledge that nobody has come to my residence or otherwise contacted to inform me that I should or must come to this clinic for therapy due to the accident on _____ that caused my injury.

Patient or Guardian Signature: _____

Patient or Guardian Printed Name: _____

Date: ____ / ____ / _____

---

8. Informed Consent & Authorization

I, _____, understand that as part of my health care, Houston Medical Group, originates and maintains paper and/or electronic records regarding my health history, exam and test results, treatment and plans for future management. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were provided, and
- A tool for clinic operations, i.e. assessing quality & competence of medical professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete account of information uses and disclosures. I understand I have the following rights:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to restrict how my records are used or disclosed to carry out treatment, payment or health care operations.

I understand that Houston Medical Group is not required to agree to the restrictions requested. I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this clinic may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.

I understand Houston Medical Group reserves the right to alter notice and practices prior to completion, in accord with Section 164.520 of the Code of Federal Regulations. If Houston Medical Group alters notice, if requested, a copy will be sent to the address I supply (U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand for this organization's treatment, payment or care operations, it may be necessary to release my health records to another entity; I consent to disclosure for these uses, including via fax.

I fully understand and accept/decline the terms of this consent.

Patient or Guardian Signature: _____
Patient or Guardian Printed Name: _____
Date: ____ / ____ / _____

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PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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Disclosure of Protected Health Information (PHI) HIPAA Release

Patient's Name: _____Birthdate: _____

Address: _____ City _____ State _____ Zip Code_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices from **HOUSTON MEDICAL GROUP**.
A copy of this signed, dated document shall be as effective as the original.
** MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE/MY REPRESENTATIVE*

HOSPITAL/FACILITY VISITED: _____

Address: _____ City _____ State _____ Zip Code_____

ATTORNEY'S OFFICE NAME: _____

Address: _____ City _____ State _____ Zip Code_____

Records to be disclosed related to the following date(s) of service _____

☐ All Medical Record ☐ Lab Results ☐Physician Orders ☐Prescriptions ☐Itemized Bill ☐X-ray ☐Other

ENTITY / PERSON MAY RECEIVE COPIES OF MY RECORDS BY: ☐ Mail ☐ Pick up ☐Fax ☐ Email

Name: **Houston Medical Group**

Address: _____ City _____ State _____ Zip Code_____

Phone Number: _____ Fax Number: _____

Email: _____

CONNECTION WITH THIS AUTHORIZATION:

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficient Syndrome (AIDS). To authorize disclosure of the following sensitive information listed below: Please check box below: ☐ HIV/AIDS-related Testing and/ or Treatment ☐ Sexually Transmitted Diseases ☐ Alcohol / Drug Abuse Treatment ☐ Mental Health -Testing / Treatment ☐ None of the listed health records.

• I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Houston Medical Group, by providing a written request to the Organization where my care was provided.

• I understand that if the entity/person that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such entity/person and will likely no longer be protected under the federal privacy regulations.

• I understand that Houston Medical Group may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.

• I understand that this authorization expires one year from date of authorization, or revoked on date specified here _____/_____/_____. Additionally, applicable State Law may specify a shorter duration.

• I have a right to receive a copy of this authorization.

Patient or Guardian Signature: _____

Patient or Guardian Printed Name: _____

Relation with the Patient (if patient is a minor): □ Parent □ Legal Guardian □ Relative □ Family Member

Date: ____ / ____ / _____

CONFIDENTIALITY STATEMENT

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes. We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

Your Test Results - You and only you receive your test results unless you direct us in writing to forward your results to a medical practitioner or an additional 3rd party. Although some positive results such as HIV are required to be reported to certain government agencies, only the minimum required information will be reported.

YOUR PRIVACY IS IMPORTANT TO US AND WE USE EVERY CARE TO SECURE YOUR PRIVACY RIGHTS!

HIPAA: Health Insurance Portability and Accountability Act - This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully. In compliance with the 1996 Congressional Act to protect the privacy of patients' protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes:

Treatment: Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may include, but is not limited to:

History and physical, progress notes, laboratory reports, x-ray results, operative reports, consultation reports, hospital discharge reports, hospital DNR, to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient/client's present and future care.

Payment: Information requested by the Insurance Company, necessary for the processing of claims for payment of services.

Operations: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure.

If you feel that your privacy rights have been violated you may contact us and ask for the Director or Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint.

We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request.

Patient or Guardian Signature: _____

Patient or Guardian Printed Name: _____

Relation with the Patient (if patient is a minor): □ Parent □ Legal Guardian □ Relative □ Family Member

Date: ____ / ____ / _____

INFORMED CONSENT & LIABILITY RELEASE TO CHIROPRACTIC MEDICINE/PHYSICAL THERAPY

I have been informed of and acknowledge that participation in physical medicine/therapy involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, is a potentially hazardous activity. I have also been informed of and acknowledge that participation in physical medicine can be a test of a person's physical and mental limits and that such participation and training poses potential risks of serious bodily injury or death.

I UNDERSTAND AND AM INFORMED THAT, AS IN THE PRACTICE OF MEDICINE, IN THE PRACTICE OF CHIROPRACTIC THERE ARE SOME RISKS TO TREATMENT, INCLUDING BUT NOT LIMITED TO FRACTURES, DISC INJURIES, STROKES, DISLOCATIONS AND SPRAINS. I DO NOT EXPECT THE DOCTOR TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS, AND I WISH TO RELY UPON THE DOCTOR TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN TO HIM OR HER, IS IN MY BEST INTEREST. I HEREBY ACCEPT THE RESPONSIBILITY FOR ANY HARM, INJURY OR DAMAGE THAT MAY RESULT FROM CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING VARIOUS MODES OF PHYSICAL MEDICINE.I HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY AND AGREE TO HOLD HOUSTON MEDICAL GROUP, ITS OFFICERS, EMPLOYEES AND AFFILIATES FOR ANY CLAIM ARISING OUT OF ANY INJURY TO ME, WHETHER THE RESULT OF NEGLIGENCE OR ANY CAUSE. I VOLUNTARILY AND KNOWINGLY ACKNOWLEDGE, ACCEPT AND ASSUME THESE RISKS.

I have read this waiver and release of claims and covenant not to sue. I am aware that this is an agreement not to sue and constitutes a complete release of liability by me and by the program participant. I acknowledge that I am signing this document of my own free will, with full knowledge of the risks being assumed.

I agree to the following:

1. My participation in chiropractic treatment, physical medicine and training is strictly voluntary.
2. My participation in each and every exercise and activity within the physical medicine training program is voluntary and I may choose not to participate, or limit my participation, in any exercise or activity at any time.
3. I am personally responsible for my own safety while participating in the physical medicine program. I will pace myself to maintain a level of participation that is safe and comfortable for me.
4. I will advise my chiropractor/medical doctor/chiropractic assistant of any changes in my physical or mental health prior to participation in each session.
5. My chiropractor/chiropractic assistant/medical doctor is available to answer any questions or concerns that I might have regarding my participation, activities, or safety.
6. I will seek further direction or explanation of anything that I do not fully understand, or that causes me concern.

INFORMED AND CONSENT TO MEDICAL SERVICES: I have been informed of and acknowledge that participation in medical services, involving physical exam, physician prescribing services, medical diagnostic laboratory and testing services, can potentially have emergency medical condition arising from treatment program or treatment adversely affecting.

PREGNANCY DISCLAIMER: I do hereby state and assure that it is not possible that I am or might be pregnant at this time. I understand that this facility and /or employees will take every precaution to safeguard my well-being. Therefore, I release Houston Medical Group and/or whomever they may designate and/or their assistants from any and all responsibility and liability regarding this matter.

MINOR'S RELEASE: I hereby give written authorization to whoever is designated to administer such treatment as prescribed by himself or the designated doctor and/or assistant(s) to my minor child. I hereby certify that I have read and fully understand the above mentioned authorization for treatment, the reasons why treatment is considered necessary, its advantages, and possible complications, if any, which were explained to me by the doctor and/or a designated assistant. I further certify that no guarantee of assurance has been made as to the results that may be obtained. I also release and authorize whoever is designated to release any medical information necessary in the processing of this claim to an insurance carrier(s) and/or attorney.

INFORMED CONSENT TO MEDICAL CONSULTATION AND TREATMENT:

In general terms, I agree to receive a general medical consultation and treatment for my injury. I understand I may or may not be prescribed medications to help alleviate my pain. I understand expected results, common side effects, and possible risks may occur with use of medications.

I hereby accept the responsibility for any harm, injury or damage that may result from medical services and treatment provided by Houston Medical Group and entire organization.

I also agree to immediately go to the nearest hospital medical emergency room at the time of any type of medical emergency or medical condition that believes requires the immediate medical attention which arises from any treatment, service, products, prescription drug provided by Houston Medical Group., any employee, agent, independent medical physician, or physician assistant and nurse that covering for the medical physician.

I ALSO UNDERSTAND THAT I MAY REFUSE TO TAKE MEDICATION WHEN IT IS OFFERED AND/OR REVOKE CONSENT AT ANY TIME. I UNDERSTAND THAT IF SUCH REFUSAL WOULD BE UNSAFE TO THE CONSUMER OR OTHERS, MEDICATION MAY BE GIVEN INVOLUNTARILY. I UNDERSTAND I HAVE THE RIGHT TO FILE HUMAN RIGHTS COMPLAINT OR TO SEEK JUDICIAL PROTECTION OF CONSUMER'S RIGHTS OR PRIVILEGES AS PROVIDED BY LAW.

Patient or Guardian Signature: _____
Patient or Guardian Printed Name: _____
Date: ____ / ____ / _____

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ASSIGNMENT OF BENEFITS: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Thanh Pham, DC, Eric Nicastro, DC, Brooke Thibodeaux, DC, Swynda Barajas, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. A letter of protection issued by an attorney's office will not negate this assignment.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to Houston Medical Group, and send to 4771 Sweetwater Blvd #143 Sugar Land, TX 77479. I instruct my attorney to provide on request to the above named provider, a settlement breakdown in accordance with the Safekeeping Property Rule, Sec. 1.14.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Houston Medical Group, and to send any and all checks to 4771 Sweetwater Blvd #143 Sugar Land, TX 77479.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from ay other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

Patient or Guardian Signature: _____

Patient or Guardian Printed Name: _____

Relation with the Patient (if patient is a minor): □ Parent □ Legal Guardian □ Relative □ Family Member

Date: ____ / ____ / _____

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PATIENT CONSENT TO THE USE OF TELEMEDICINE

Telemedicine involves the use of electronic communications to allow patients at a location remote from the health care provider, or health-care providers at different locations to share patient medical information to help improve patient care. Providers may include main doctors, specialists, and/or subspecialists (distant specialist). The information may be used for diagnosis, therapy, follow-up, and/or education. It may also 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 films.

Electronic systems used will incorporate network and software security protocols to protect private patient information and imaging data. It will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

Expected Benefits: Improved access to medical care, obtaining expertise of a distant specialist.

Possible Risks: information may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision-making by the physician and consultant(s).Delays in medical evaluation and treatment could occur due to equipment problems or failures. If this occurs, I understand that it is my responsibility to obtain follow up care or assistance. In very rare instances, security protocols could fail, causing a breach of private personal medical information. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By giving my consent:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that no information obtained in the use of telemedicine, which identifies me, will be disclosed to other entities without my consent.
- 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.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction. I understand that I may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My medical team has explained the alternatives to my satisfaction.
- 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 or out of the country.
- I understand that it is my duty to inform my medical team of electronic interactions regarding my care that I may have with other healthcare providers.
- 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.
- I understand that I may need to be seen in person if, in my provider's discretion, it is necessary for any reason.

I have read and understand the information provided above regarding telemedicine. I have discussed it with my provider as may be designated, and all of my questions have been answered to my satisfaction. If this informed consent is being signed in advance of an upcoming telemedicine visit, I understand that this document must be signed before the visit can occur, however I can call my clinic with any questions prior to signing. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby approve the use of telemedicine in the course of my diagnosis and treatment.

Patient or Guardian Signature: _____

Patient or Guardian Printed Name: _____

Date: ____ / ____ / _____