Oakview Dermatology General Consent Form

Consent to Medical Care and Treatment: I consent to all medical and surgical care, examinations, procedures, and tests which are determined to be necessary for me while I am a patient at Oakview Dermatology. I understand that medical care requires my cooperation, and I will follow my provider's orders and prescriptions. If indicated, I will make and keep appointment for follow up care and call the office to note any changes or concerns in my condition. I understand that the practice of medicine and surgery is not an exact science, and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the result(s) of any treatment, procedure, or examinations to be performed on me while I am a patient of Oakview Dermatology.

Refusal of Treatment: I understand that if I refuse treatment that is suggested for me or I do not complete a treatment protocol recommended to me, I will not hold Oakview Dermatology, nor any individual responsible for the consequences of my refusal or incompletion.

Release of Information: I authorize Oakview Dermatology to disclose copies of all or any part of my medical records obtained in the course of my diagnosis and treatment to any insurance carrier, workers compensation carrier, welfare agency, or any other entity, which may be providing financial assistance for my hospital, medical and/or nursing care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV) testing, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related condition(s), psychiatric condition(s), and/or alcoholism or drug abuse. I also authorize the release of medical information for utilization and quality assurance review to my insurers or their subcontractors and as required by any city, state, or federal laws. I authorize this facility to disclose medical information to my family physician, referring physician, or any other provider directly involved in my medical care.

Communication Methods: I expressly authorize Oakview Dermatology, its affiliates, and third-party service providers to email, call, or text (collectively "communications") me on the cellular phone and/or other telephone number(s) that are provided to Oakview Dermatology on this form or updated at a later time. Additionally, I acknowledge that these communications may use live, artificial, or pre-recorded voices, automatic dialing systems, email, or other computer-aided technology from Oakview Dermatology and its affiliates. Such communications may be related to any purpose, including those related to my account, care rendered to me, or my future care. Please note, that under HIPAA texting is not a secure medium to share Protected Health Information, so please do not respond to text messages with this sensitive information. I understand that this consent to communications is not required to receive services from Oakview Dermatology or its affiliates, and that I may opt out of these

communications at any time. Furthermore, I acknowledge that standard data usage and messaging rates may apply to these communications from Oakview Dermatology to me.

Remote/Virtual Medical Scribe

Your provider may use a virtual medical scribe to assist in documenting your medical visit using a HIPAA compliant platform. A virtual scribe is a trained professional who listens to your visit remotely in real time and enters information into your medical record. In-person and remote scribes are bound by strict confidentiality rules under federal (HIPAA) and state privacy laws. I may decline the use of a remote scribe at any time and it will not affect the quality of your care.

Bi-Directional Health Information Exchange: Health information exchange (HIE) is the secure and seamless sharing of patient medical information electronically between healthcare organizations such as hospitals, clinics, laboratories, and physicians' offices. Healthcare providers use HIE to access crucial patient data at the point of care, regardless of where patient records originated to reduce medical errors, enhance efficiency, and improve patient outcomes. I understand that I will be opted in for the HIE, but I have the option to opt out at any time by asking a staff member or utilizing my patient portal.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby assign to Oakview Dermatology all right, title, and interest in and to any third-party benefits due from any and all insurance policies employee benefit plans and/or responsible third-party payers in an amount not to exceed Oakview Dermatology's regular and customary charges for the health care services rendered. I authorize such payments from my insurance carriers, third-party payers, and any other third-parties. I consent to any request for review or appeal by Oakview Dermatology to challenge a determination of benefits made by a third-party payer, insurance carrier or employee benefit plan. Except as required by law, I assume responsibility for determining in advance whether the services provided to me are covered by my insurance or other third-party payer.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between Oakview Dermatology and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient named below, I agree to be financially responsible and obligated to pay Oakview Dermatology for its total charges not paid under the "Assignment of Benefits" made below. All balances must be paid within thirty (30) days after receipt of a statement. I understand that I will be responsible for the costs of any services rendered to me that are not eligible for benefits under Medicare, Medicaid, insurance or other payors.

Statement to Permit Payment of Medical Benefits to Provider and Physician(s): I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information need for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to Oakview Dermatology and to physicians and groups providing medical care to me.

General Consent Form

Tobacco-Free Information: Tobacco use of any kind is not allowed inside or outside of Oakview Dermatology's facilities. Compliance with Oakview Dermatology's tobacco-free policy is expected of all patients and visitors.

Privacy Notice: I have been offered a copy of Oakview Dermatology's Notice of Privacy Practices within the past year.

Personal Valuables: Oakview Dermatology is not responsible for any lost, stolen, or damaged personal items.

Nondiscrimination Statement: Oakview Dermatology complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnicity, religion, culture, language, age, disability, socioeconomic status, sex, sexual orientation, and gender identity or expression in its health programs and activities.

Teaching Facility*:* I understand that this facility is a teaching facility and I consent to allow medical students, interns, residents, fellows, nurses and other health care personnel assisting and/or participating with my physician(s) in the performance of the diagnostic, medical, and surgical procedures which may be performed upon me under my physicians' direction and supervision.

Patient Rights: I reviewed the "Patient's Rights" information posted in the office.

Acknowledgment - By signing below I acknowledge that I have read and understand this Consent and Authorization and that I have been given the opportunity to ask questions and receive clarification so that I fully understand and agree to this Consent and Authorization:

Patient Name	Date of Birth
Patient or Legal Guardian Signature	Today’s Date