PATIENT CONSENT TO TREAT

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Randy Long MD and I consent to all medical and surgical care, examinations and tests determined by my Practitioner to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Practitioner's recommendations as they may relate to my health that the Practitioner and Randy Long MD will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Randy Long MD is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that Randy Long MD may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Randy Long MD's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Trinity Health credentialed practitioners/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). Randy Long MD has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent I agree that Randy Long MD may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of practitioners and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to Randy Long MD's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as Randy Long MD's participation in any health information exchange described in Randy Long MD's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

3. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Randy Long MD's Consent to Use and Disclose Protected Health Information which provides information on how Randy Long MD may use or disclose PHI for purposes of treatment, payment, or health care operations. Please Initial _____

4. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to Randy Long MD for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

5. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my practitioner determines to be medically necessary, but are later determined unnecessary by the payer.

6. PERSONAL VALUABLES. I understand that Randy Long MD does not accept responsibility for any lost, stolen or damaged personal items while I am at Randy Long MD.

Patient Name: _____ Patient Date of Birth: _____

_____ _____

Signature of Patient or Patient's Legal Representative | Date of Signature

_____ _____

Print Name of Patient's Legal Representative | Relationship of Legal Representative to Patient (e.g., parent, guardian, other, please explain)