GoPrivateMD

CONSENT FOR MEDICAL TREATMENT

1. CONSENT TO MEDICAL CARE AND TREATMENT: I am being treated by GoPrivateMD, and I consent to all medical and surgical care, examinations and tests determined by my Physician that are 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 Physician's recommendations as they may relate to my health that the Physician and this Office 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 Physician Office 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 may be charged for testing related to the exposure.

2. CONSENT TO USE OF ELECTRONIC HEALTH RECORD: I understand that the Physician Office may collaborate with other health care providers, including the NM Health Information Exchange to coordinate, manage and provide health care to me and I consent to the Physician Office'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 understand I can opt out of the NM Health Information Exchange by calling 505-938-9900 or on their website at www.nmhic.org. 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. The electronic health records (EHR) may be accessible by other credentialed physicians/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"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

3. FINANCIAL RESPONSIBILITY: I understand and agree that I am financially responsible for payment of all charges incurred, including any and all products provided or services rendered to me and that GoPrivateMD does not participate in my insurance network and will not bill my insurance.

Patient Name: _____ Date of Birth: _____

Address / City / State / Zip Code:_____

Phone:_____ Email:_____

_____ _____

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

_____

If Applicable, Print Name of Legal Representative & Relationship to Patient (e.g., parent, guardian)