CONSENT AND RELEASES

Consent for Treatment

I, ____, hereby voluntarily consent to outpatient care at Piedmont Internal Medicine, PC encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the physician's judgment.

Patient/Authorized Signature: ____Date_________
If Patient is a Minor (under 18), Authorized Signature: ____

Notice of Patient Privacy Consent (HIPAA)

I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.PiedmontInternalMed.com for your convenience.)

Patient Signature: ____ Date: _______________________

Authorized Release of Medical Information

There are times where the physicians and employees of Piedmont Internal Medicine need to contact you. Our primary method is through our "My Chart" patient portal, however, circumstances may require us to contact you via email, telephone, voice mail, and/or text messaging. Please check the additional approved methods of how we may contact you regarding your personal and private health information. Please note, you may change or revoke your authorization approvals at any time. ***Check all that apply:***

_____ Home Voice Mail/Answering Machine _____ Text Message _____ Work Voice Mail
_____ Cell Phone Voice Mail _____ Personal Email _____ Work Email
_____ Other: ____

I authorize the release of medical information to the following: ____
____
Name and Relationship Name and Relationship

Patient Signature: ____Date: _______________________

Lifetime Medicare Authorization & Consent for Medicare Patients Only

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX 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 or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance

amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount.

I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature: ____Date: ______________________

Medigap Authorization Statement

I authorize any holder or other information about me to release Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient Signature: ____Date:________________________

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

I hereby consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Patient Signature: ____Date: ______________________

Health Information Exchange

Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers. **I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.**

Substance Abuse

I authorize Piedmont Internal Medicine, P.C. to release information on Sexually Transmitted Disease and/or Chemical Dependency to file an insurance claim pertaining these diagnoses. If I am diagnosed with any of these conditions, I give consent to release my Sexually Transmitted Disease or Chemical Dependency health information if there is a need to be referred to a specialist. I also consent my health information be sent to government health entities if requested. I understand I can terminate this authorization for substance abuse care information any time, unless Piedmont Internal Medicine has already acted in reliance. I understand this authorization will be reviewed annually.

I understand if I chose to decline this portion, any services I receive related to Sexually Transmitted Disease or Chemical Dependency will need to be paid in cash at the time services are rendered. "

_____ Decline

I specifically authorize release of the following information for the purposes of treatment, payment and health care operations. If it is a part of my protected health information: (INITIAL ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE)

__________Chemical Dependency/Substance Abuse __________ Sexually Transmitted Diseases

Patient Signature: ____Date: ______________________

Terminating Services

All the providers and staff at Piedmont Internal Medicine value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies, including yearly physical exams.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections

In such cases where the practice terminates the relationship, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice, and will send medical records to your new provider with a written release.

I have read and understand the reasons Piedmont Internal Medicine and my Provider may terminate the patient/provider relationship.

Patient Signature: ____Date: _____________________