Village Medical

at Home

Patient Consent Form

CONSENT TO TREATMENT

You have the right, as a patient, to be informed about your condition and the recommended treatment plan so that you can make informed decisions about your treatment. This Consent to Treatment gives us permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for an identified condition(s).

This Consent to Treatment provides Village Medical at Home with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signature below, I indicate that:

1. I, consent to treatment in my home or any other location where I reside by Village Medical at Home.

2. I, voluntarily consent and authorize the physicians and other clinical providers of Village Medical at Home, for the evaluation, testing and treatment of the conditions for which I present.

3. I, acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by the physicians and other clinical providers of Village Medical at Home, and I promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided.

4. I, hereby authorize Village Medical at Home to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

I, voluntarily request Village Medical at Home through its providers, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to Village Medical at Home in my home or other location where I may reside. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms.

This Consent will remain fully effective until revoked in writing, at any time. You can revoke this Consent and stop your relationship with Village Medical at Home at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to this Consent to Treatment.

Patient Initials: _____

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Village Medical at Home to use and disclose my PHI in the following ways:

- Treatment (including direct or indirect treatment by other healthcare providers involved with my care and requests to obtain or release medical records from other physicians or facilities as necessary);
- Obtaining payment from third party payer (e.g. My insurance company);
- The day-to-day healthcare operations of Village Medical at Home healthcare practice, including sharing with third party vendors, some of which may require a separate consent;

I understand that the third-party vendors who ask for my PHI are legally obligated to abide by the requirements of the HIPAA and are required to maintain the security and confidentiality of my information. I understand that if I wish to optimize my experience and enhance continuity of my care, I must voluntarily opt-in by providing express consent (below) to sharing my information with third-party vendors.

I have also been informed of and given the right to review and receive a copy of the Joint Notice of Privacy Practices, which includes a description of the use and disclosure of my PHI, and my rights under HIPAA. I understand that you may change the terms of this Notice from time to time and that I can always ask for a current copy of the Notice.

I understand that I can request restrictions on how my PHI is used and disclosed to carry out treatment, payment, and health care operation, and that you are then required to comply with this restriction.

I understand that I can revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date consent is revoked will not be affected.

Patient Initials: _____

PERMISSION TO VERBALLY DISCUSS MEDICAL INFORMATION

This consent allows Village Medical at Home or Village Medical Clinical Pharmacists to verbally discuss your medical and sensitive information with the person(s) named below.

I hereby authorize Village Medical at Home to verbally discuss information about me with:

Name	Relationship	Phone number

This authorization shall be effective immediately. I can understand that I can revoke this consent, in writing, at any time.

Permission for further use or disclosure of your medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient Initials: _____

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ELECTRONIC COMMUNICATION CONSENT

I understand and agree that Village Medical at Home may contact me using automated calls, emails, and text messages sent to my landline and cellular numbers or e-mail set forth below.

Village Medical may utilize electronic communications to:

- Notify me of notices available in the Patient Portal, preventive care, test results, treatment recommendations, outstanding balances;
- Remind me of scheduled appointments;
- Market and share information with me regarding new services provided by Village Medical @ Home; or
- Any other Village Medical at Home communications.

I understand that I must voluntarily consent to receive automated electronic communications, including text messages and e-mails by signature below or by visiting the Patient Portal and consenting electronically. I understand that I may be charged for such calls by my telephone service provider(s) and that such calls may be generated by an automated dialing system. Village Medical at Home will not charge you for these communications. I understand that there are risks associated with electronic communication. Village Medical at Home will utilize secure encryption methods to minimize risk.

I understand that I may revoke this consent at any time in writing or orally to Village Medical at Home.

Patient Initials: _____

CONSENT TO PHOTOGRAPH

I hereby consent to permit the staff, physicians and/or affiliated practitioners of Village Medical at Home to record photographs, videotapes, digital or other images to document my care as part of the following medical procedure or course of treatment _____ [insert name of procedure].

I understand that this consent is valid to permit Village Medical at Home staff to record images throughout this procedure or course of treatment but not to record images for any other purposes. I understand that Village Medical at Home will retain the ownership rights to these images but that they will be part of my medical record and that I will be allowed access to them as set forth in Village Medical at Home's Joint Notice of Privacy Practices. I understand that these images will be stored with my medical records and will be kept for the time period required by law or set forth in Village Medical at Home's policy. I understand that these images will only be used or disclosed pursuant to Village Medical at Home's Joint Notice of Privacy Practices Policy.

Patient Initials: _____

Village Medical at Home

Patient Consent Form

I hereby certify that I have read the above Patient Consent Form, initialized, and hereby provide my consent:

Name of Patient (Printed)		
Signature		
Date		
Consent to sharing health-related information with third party vendors (circle one)	Opt-In	Opt-Out
Home Number		
Cellular Number		
E-mail		