PHIPPS FAMILY MEDICINE

General Consent Form

Patient Name:_____ Date of Birth:_____/_____/_____

Assignment of Benefits. I authorize Phipps Family Medicine to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that PFM will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for Phipps Family Medicine to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, Phipps Family Medicine may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at Phipps Family Medicine's expense.

Patient Initials: _____

Electronic Prescription. I understand Phipps Family Medicine utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: _____

Communication. By providing contact information, I authorize Phipps Family Medicine, its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me. Please check which form(s) of communication you would like to receive from Phipps Family Medicine.

Phone ☐ Voicemail (detailed) ☐ E-mail ☐ Text Message ☐ Patient Portal ☐

Late Arrival Policy. A grace period of 10 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the clinic location for their appointment. If a patient arrives more than 10 minutes late for their appointment, the patient will be given the option of either being seen that day as a walk-in, if the schedule permits, or rescheduled for a later date. This process will ensure patients that do arrive on time are seen in a timely manner.

Patient Initials: _____

No-Show/ Cancelation Policy. A "no-show" is a patient who fails to appear for a scheduled appointment without providing **24-hour cancelation notice**. Further, a rescheduled appointment that is less than the **24-hour cancelation notice** is still considered a cancelation and is treated as such. All patients who have **two (2) no-show appointments will then be charged $30 and once three (3) no-show appointments have been reached**, the patient will be **dismissed** from Phipps Family Medicine's practice.

Patient Initials: _____

Involvement of Others in Care. I authorize Phipps Family Medicine to discuss my/the patient's care and medical needs with the following persons:

I DO NOT wish to add a contact(s) to discuss my/the patient's needs or medical care.

Name	Date of Birth (for identification)	Relationship	Phone

☐ Patient Initials: _____

Patient Acknowledgment of Insurance Requirements for Minimum Visits. As a patient under the care of Phipps Family Medicine, I hereby acknowledge and understand the following conditions set forth by my health insurance plan:

1. Minimum Visit Requirement: My insurance plan requires that I be seen by a healthcare provider at least **twice per year** as a condition for continued coverage and benefit eligibility.
2. Purpose of Visits: These visits are intended to ensure ongoing monitoring of my health status, provide preventive care, and address any emerging health concerns in a timely manner.
3. Financial Responsibility: I understand that failure to comply with this minimum visit requirement may affect my insurance benefits and could result in higher out-of-pocket costs for medical services. I acknowledge that it is my responsibility to schedule and attend these appointments within the required timeframe.
4. Appointment Scheduling: I agree to proactively communicate with Phipps Family Medicine to schedule the necessary appointments as per my insurance plan's requirements. I will inform the clinic/physician if there are any changes in my insurance coverage or if I encounter any barriers to meeting this requirement.

I understand that if I do not comply that I am putting Phipps Family Medicine at risk for losing insurance payor contracts which can lead to unforeseen problems for the practice which could put all parties in jeopardy.

Patient Initials: _____

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Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." Patient Initials: _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." Patient Initials: _____

Minor Patient Photograph (when applicable)

I consent for Phipps Family Medicine to photograph the minor patient for identification purposes only.

Patient Initials: _____

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Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date