Patient Name: _____ **Date of Birth:** _____

MEDICAL CONSENT

I voluntarily consent to care at Bryan Health Physician Practices (Bryan), including routine, diagnostic procedures and medical treatment such as examinations, blood tests, x-rays, blood transfusions, photographs, therapies and other procedures that my physician, and other physicians and health care providers may deem necessary and appropriate. I understand that no guarantees have been made as to the results of such medical care. I agree to all the terms and conditions as described in this financial and treatment agreement. I understand that some procedures and treatments will be performed by Bryan employees, and others by independent practitioners who are neither employees nor agents of Bryan. I hereby consent to the use of telemedicine/telehealth services. I understand the service provider will be at a different location from me. I can decline telemedicine/telehealth services at any time without affecting my right to future care or treatment to which I would otherwise be entitled. Bryan personnel will use real time video with audio or audio only to communicate and share necessary details of my medical history, examinations, diagnostic testing and/or results, photographs or other images. The same confidentiality protections that apply to my "in person" or face to face medical care apply to the telemedicine/telehealth service provided. Access to all medical information resulting from the telemedicine/telehealth service will be available as provided by law. Dissemination of my patient identifiable images or information from a telehealth visit to researchers or other entities will not occur without my additional consent to do so. I also understand that students, residents, fellows, medical trainees and medical company representatives may observe my procedures and treatments, and, when allowed by law and properly supervised by qualified personnel, may participate in performance of such services I authorize Bryan to collect, use, and disclose information to a third party engaged in the collection or dissemination of my medication information. In some cases, proper treatment of a medical condition requires continuing treatment or diagnosis over a course of repeated outpatient visits. In such cases, the request, consent, and agreement contained herein apply to all repeat visits and all continuing treatment and diagnosis for the same condition.

FINANCIAL AGREEMENT AND RELEASE

I agree to pay Bryan and other health care providers for services rendered to me at the rates now in effect or to become effective during the course of my treatment. It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am hospitalized without authorization, I will be responsible personally for all or part of the cost of hospitalization and professional services. I understand that all billings for services are due and payable at the time of service. If there is an overpayment by me or on my behalf, or by my insurance carrier, I direct Bryan or other health care providers to apply the overpayment to any other unpaid account I may have with them. I understand that Bryan and other health care providers are unable to finance patient account balances and may at their option, contract with independent agencies, finance companies and/or financial institutions to make financial information and services available for patients with outstanding account balances. I authorize the disclosure of patient demographic and financial information, including but not limited to the amount of my outstanding account balance, from my record for the purpose of making such financial information and services available to me.

AGREEMENT OF INSURANCE BENEFITS

I assign to Bryan all insurance benefits to which I may be entitled to the extent of professional charges owed to Bryan. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits, and the proceeds of any settlement, structured or otherwise, or judgement awarded for personal injuries caused by a third party. I hereby authorize direct payment of all such insurance benefits to Bryan and I agree to pay for any and all hospital charges not paid pursuant to this agreement. I also assign insurance benefits to which I may be entitled, as defined in the previous paragraph, to persons, corporations or their entities providing health care services to me in cooperation with Bryan, its staff and employees during my hospitalization, whose services are deemed necessary and requested by my treating physician.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of all or any part of the contents of my medical record to the following: (1) to persons, corporations or other entities involved in my medical care or part of my medical care provider team for the purpose of immediate treatment, continuity of care and/or payment for healthcare operations.

TELEPHONE NUMBERS

By providing us with your landline or cell phone number(s), you are giving your consent for us, our agents, and to our collection agents, to contact you at these numbers, or at any number that is later acquired by you, and to leave live, pre-recorded, or text messages regarding accounts, billing, services, appointments, surveys, or marketing material. For greater efficiency, calls may be delivered by an autodialer. Providing us a telephone or cell number is not a condition of receiving our services, however.

VERBAL COMMUNICATION

Bryan Health may communicate information to the following people regarding my care as needed or on an emergent basis:
❑ **DO NOT** speak to anyone about my health status - **Leave contacts blank**

		Type of information			
		All	Scheduling/ Appointments	Medical	Billing/ insurance
Name: _____		❑	❑	❑	❑
Relationship: _____	Phone Number: _____				
Name: _____		❑	❑	❑	❑
Relationship: _____	Phone Number: _____				
Name: _____		❑	❑	❑	❑
Relationship: _____	Phone Number: _____				

INFORMATIONAL

I acknowledge receipt of the Notice of Privacy Practices.

The undersigned certifies that he/she is the patient or is duly authorized by the patient to sign this document for the patient, that he/she has read and understands the contents stated above, and that he/she agrees to the items noted in this medical and financial consent form. The information which has been provided is true and complete. A photocopy of this medical and financial consent form shall be as valid as the original.

Patient or Person Authorized to Consent for Patient / Relationship (if not patient)	Date	Time
Printed Patient Name	Date of Birth	
Reason Patient was Unable to Consent or Sign	Date	Time
Clinic Rep - Witness to Signature	Date	Time
Secondary Witness to Signature if Telephone/Verbal Consent	Date	Time

Interpreter Declaration (Consent signature must be complete)
I have interpreted the form for the patient or patient and/or the patient's representative in the _____ language. The form as, completed above, was reviewed in my presence with the patient or patient's representative.

Interpreter's Name: _____

Signature of Interpreter _____ Date / Time _____ OR _____ Remote Interpreting Number _____

Bryan Health

CLINIC MEDICAL AND FINANCIAL CONSENT

Place Patient Label Here

Epic: PAT level to Consent to Treat - Clinic Annual
Description: Clinic Name
Form M1150 (Rev. 12/23)