PATIENT NAME____DATE OF BIRTH__________________________

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership this includes in person or telemedicine visits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a Physician, and/or Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ________________________________

Signature of Patient or Personal Representative Date

PATIENT INFORMATION

NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE, ZIP	HOME PHONE	CELL PHONE
SECONDARY/BILLING ADDRESS (If applicable)	CITY, STATE, ZIP	EMAIL ADDRESS	SMOKER? Y / N

MARITAL STATUS	STUDENT STATUS	PRIMARY CARE PROVIDER
EMERGENCY CONTACT NAME AND PHONE NUMBER (PERSON NOT LIVING WITH YOU)		

HOW DID YOU HEAR ABOUT OUR OFFICE?
- ☐ Website ☐ Facebook / Pinterest / Twitter
- ☐ Referred by: ___________________________
- ☐ Billboard ☐ PBS ☐ Valley Times
- ☐ Other: ________________________________

WITH WHOM MAY WE DISCUSS YOUR MEDICAL INFORMATION? (PLEASE WRITE OUT SPOUSE, PARENT, ONLY ME, OR OTHER NAME)

PATIENT EMPLOYER		SPOUSE EMPLOYER	
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
WORK PHONE	OCCUPATION	WORK PHONE	OCCUPATION

INFORMATION OF PRIMARY SUBSCRIBER ON INSURANCE (If different from above)

NAME (Last, First Middle)	SSN#	BIRTH DATE	SEX

LOCAL ADDRESS	CITY, STATE, ZIP	SECONDARY/BILLING ADDRESS (IF APPLICABLE)

HOME PHONE	CELL PHONE	WORK PHONE	CITY, STATE, ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER? Y / N	VETERAN? Y / N	PRIMARY CARE PROVIDER	EMAIL ADDRESS

RELATIONSHIP TO PATIENT	EMPLOYER / OCCUPATION

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		POLIICY #
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMOUNT
CITY, STATE, ZIP	PHONE #	DEDUCTIBLE
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE INFORMATION (If Applicable)

NAME OF INSURANCE COMPANY		POLIICY #
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMOUNT
CITY, STATE, ZIP	PHONE #	DEDUCTIBLE
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

NAME (Last, First Middle)	SSN#	BIRTHDATE

I understand that MomDoc participates in many insurance plans. If I am not sure if my insurance is one of those accepted, I should call my plan and inquire if MomDoc is part of my network. I understand that it is my responsibility to get any needed referrals before my visit. I understand that it is my responsibility to know and understand my benefits and coverage. I understand that I may request a refund of any credits on my account once all claims have been processed and paid.

I understand that all professional services rendered are charged to me, and that I am responsible for all fees, regardless of insurance coverage. I understand that it is customary for payment to be made when services are rendered unless other arrangements have been made in advance with an office manager. I understand that all co-pays are expected before being seen. I understand that reasonable late fees or collections fees may be assessed in the event of late payment or non-payment of balance.

I request that payment of authorized Medicare/insurance company benefits be made either to me or on my behalf to MomDoc for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or insurance 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. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provide penalties for withholding this information.)

I have read and have been offered a copy of the Notice of Privacy Practices for Protected Health Information and a copy of MomDoc Patient Rights.

SIGNATURE____________________________________ DATE__________________________

Notice of Patient Rights

MomDoc's Administrator shall ensure that at the time of admission (New patient visit) a patient or the patient's representative is given a written copy of the patient rights. The administrator will also ensure that a copy of MomDoc's patient rights are posted in a conspicuous spot at each MomDoc location along with our current license from the Arizona Department of Health Services. MomDoc's Administrator will ensure that each patient is treated with respect, consideration and dignity and will ensure that patients are not subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or sexual assault, restraint or seclusion unless allowed in Arizona Health Statute R9-10-1012(B). The Administrator will ensure that retaliation for submitting a complaint to the Department or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel members will not be tolerated.

MomDoc's Administrator will ensure the following happens as appropriate (unless in an emergency):

- Patient or the patient's representative may consent to or refuse treatment.
- Patient or the patient's representative may refuse or withdraw consent for treatment before treatment is initiated.
- Patient will be informed of alternatives to proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure.
- Patient will be informed of MomDoc's policy on health care directives or complaint process.
- Patient's consent to photographs of the patient before patient is photographed will be obtained.
- Written consent to release medical or financial records will be obtained unless permitted by law.

MomDoc's patient rights will include the following:

- To not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- To receive treatment that supports and respects the patient's individuality, choices, strengths and abilities.
- To receive privacy in treatment and care for personal needs.
- To review, upon written request, the patient's own medical records according to A. R.S. 12-2293, 12-2294 and 12-2294.01.
- To receive a referral to another health care institute if MomDoc is not authorized or not able to provide physical health services need by the patient.
- To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
- To participate or refuse to participate in research or experimental treatment.
- To receive assistance from a family member, the patient's representative or other individual in understanding, protecting or exercising the patients' rights.
- To be given follow up instructions orally or in written form before patient leaves the facility. (Unless patient leaves against a personnel member's advice.)

The following list of patient rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern and to emphasize the need for observance of these rights and responsibilities:

- Receive considerate and respectful care and ensure that care is provided in a safe environment, free from all forms of abuse, harassment or discrimination, neglect, exploitation, coercion and manipulation. MomDoc's personnel members and providers will not misuse your personal and private property.
- Know the name of the provider who is providing your care and the names and professional relationships of other providers who will be involved in your care.
- Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery, and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person that you designate on your behalf.
- Receive treatment that supports and respects your individuality, choices, strengths and abilities.
- Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent and understanding consent.
- Expect that those providing care will protect your privacy and support your personal dignity.
- Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected.
- Expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. When MomDoc releases your records to others, such as insurers, it emphasizes that the records are confidential.
- Review your own medical record upon written request and to have the information explained within a reasonable amount of time, except when restricted by law.
- Receive a referral to another health care institution if MomDoc is not authorized or not able to provide physical health services needed.
- Leave the office even against the advice of your provider.
- Be told of alternatives when hospital care is no longer appropriate.
- An itemized and detailed explanation of your complete medical bill.
- Communicate concerns/grievances regarding your care to a patient representative without fear of retaliation from the Department or any other entity.
- Receive answers to ethical questions that may arise in the course of your care.
- Access to an interpreter or translator if necessary.
- Expect that medical information disclosed about you and your rights and our obligations regarding the use and disclosure of your medical information is done in accordance with our Notice of Privacy Practices.
- Access, request amendment to and receive an accounting of disclosures regarding his/her own health information as permitted under applicable law.
- Receive follow up instructions that are given orally or in written form before you leave the outpatient center unless you leave against medical advice.

- Submit a complaint by reaching out to the medical office supervisor of your location, or by submitting a Rate your visit, found at MomDoc.com.
- Receive a response to any complaint within 24 business hours.
- Contact the Office Supervisor for a list of our scheduled rates.
- The Office Supervisor at each location has the current license inspection reports posted near their desk. Please ask for the Office Supervisor to obtain these records available for review with Administration.
- The department listed below can be contacted for a complaint regarding our facility:

Arizona Department of Health Services
150 North 18th Ave, Suite 450
Phoenix, AZ 85007-3248
(602)364-3030 Phone (602)792-0466 Fax www.azdhs.gov

- Charges for care determined to be medically necessary by a MomDoc provider will be submitted to the insurance provided by the patient. The patient is responsible for payment of copays, coinsurance, deductibles, and all other treatment not covered by their insurance plan. The patient is responsible for providing and maintaining accurate/updated insurance with MomDoc.
- I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's Health Information Exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Patient's Name: ______________________________

Patient's Signature: ______________________________ Date: __________