



CONDITIONS OF SERVICE / CONSENT FOR TREATMENT AND TELEMEDICINE CONSENT FORM

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Supportive Medicine Specialists (SMS), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following:

1. Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of the SMS medical staff who has requested care and treatment of the Patient, and others with staff privileges at SMS. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). The patient authorizes the attending or other practitioner, the medical staff of SMS, and SMS to provide Medical Treatment/Services ordered or requested by the attending or other practitioner and those acting in his or her place. The consent to receive "Medical Treatment/Services" includes, but is not limited to: care; examinations (x-ray or otherwise); laboratory procedures; medications; infusions; transfusions of blood and blood products; drugs; supplies; anesthesia; surgical procedures and medical treatments; radiation therapy; recording/filming for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive. In the event SMS determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

2. Legal Relationship between Clinic and Physician

Some of the health care professionals performing services at SMS Clinics are independent contractors and are not SMS agents or employees. Independent contractors are responsible for their own actions and SMS shall not be liable for the acts or omissions of any such independent contractors.

3. Explanation of Risk and Treatment Alternatives

Patient acknowledges that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT concerning the outcome and/or result of any Medical Treatment/Services. While routinely performed without incident, there may be material risks associated with each of these Medical Treatment/Services. The patient understands that it is not possible to list every risk for every Medical Treatment/Services and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Medical Treatment/Services. Patient also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Medical Treatment/Services. By signing this form: The Patient consents to Healthcare Professionals performing Medical Treatment/Services as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained; and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the Medical Treatment/Services; the material risks of the Medical Treatment/Services and practical alternatives to the Medical Treatment/Services.

The Medical Treatment/Services may include, but are not limited to the following:

- a). **Needle Sticks**, such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or

partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective).

b). **Physical Tests, Assessments and Treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.

c). **Administration of Medications** via appropriate route whether orally, rectally, topically or through the Patient's eyes, ears or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration, no practical alternatives exist.

d). **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation, no practical alternatives exist.

e). **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices, no practical alternatives exist.

f). **Radiological Studies** such as X-rays, CT scans or MRI scans. The material risks associated with these types of Procedures include, but are not limited to, radiation exposure.

If the Patient has any questions or concerns regarding these Medical Treatment/Services, the Patient will ask the Patient's attending provider to provide the Patient with additional information. The Patient also understands that the Patient's attending or other provider may ask the Patient to sign additional informed consent documents concerning these or other **Medical Treatment/Services**.

4. Emergency and Labor Services

The Patient understands Patient's right to receive an appropriate medical screening exam performed by a doctor, or other qualified medical professional, to determine whether the Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the SMS's staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

5. Healthcare Practitioners in Training

Patient recognizes that among those who may attend Patient at SMS are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical education. There also may be present from time to time a medical product or medical device representative. Consent is hereby given for the presence and participation of such persons as deemed appropriate by the attending physician.

6. Remaining in Patient Care Area and Closed Circuit Monitoring/Videotaping/Photography

Patient acknowledges and understands that, Patient is advised to remain in the patient care area at all times to optimize the Patient's medical care and safety. If the Patient chooses to leave the area for reasons that are not treatment-related, the Patient assumes any and all liability for any incident, accident, misadventure, or harm, including deterioration of the Patient's condition, which the Patient may suffer. The patient agrees to hold SMS, all Healthcare Professionals, harmless for any injury or harm resulting from the Patient's decision to leave the patient care area and the Patient accepts any and all responsibility for such actions. The Patient also understands that closed-circuit monitoring, videotaping, and photography of patient care may be used for educational, clinical purposes, and/or safety-related purposes.

7. Authorization to Release Information

SMS is authorized to use and release information contained in the patient record as described in the SMS Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will include but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment, information about drug or alcohol abuse or treatment of same, and/or psychiatric or psychological information. The Patient waives any privilege pertaining to such confidential information and hereby releases SMS, its agents, and employees from any and all liabilities, responsibilities, damages, claims, and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include but are not limited to, disclosures to insurance companies, their agents, or other third-party payors and/or government or social service agencies that may or will pay for any part of the medical/clinic expenses incurred or authorized by representatives of SMS; alternate care providers, including community agencies and services, for post-clinic care, as ordered by Patient's physician or as requested by Patient or Patient's family or as otherwise permitted by law; or SMS affiliates and contractors for SMS operations purposes, such as quality improvement, compliance, and risk assessment activities.

THE PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL SMS AFFILIATED ENTITIES AND PROVIDERS AND TO NON-SMS AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.

By consenting to treatment and accepting financial responsibility for any such treatment, the Patient also understands and acknowledges that (a) SMS, from time to time, may call and/or text the cell number Patient has provided or email treatment-related information to the Patient, such as appointment and exam confirmations and reminders, wellness checkups, clinic pre-registration instructions, pre-operative instructions, post-discharge follow-up, prescription notifications, Medicare-required surveys, and home healthcare instructions and (b) Patient's preferences to receive, change or stop these and other types of communications from Supportive Medicine Specialists may be done by logging into the Supportive Medicine Specialists MyChart Patient Portal at any time.

8. Patient Rights and Personal Valuables

Patient acknowledges that Patient has received a copy of Patient Rights and has verified the information utilized during this registration and confirms its accuracy. SMS shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures, unless properly secured and placed within the clinic safe.

9. Consent Timeframe and Applicability

The above consents are applicable to all outpatient clinic-based services, as well as all ambulatory and physician office based services. For outpatient-based clinic services, the above consents are valid for a period of 30 days from the date of signature below; provided, however, that if outpatient clinic-based services are provided through serial visits, the above consents will be valid for a term of one (1) year from the date of signature below. For all ambulatory or physician office based services, the above consents are valid for a period of one (1) year from the date of signature below.

Validity of Form

The Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original. Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from the Patient, the Patient's family or others having knowledge about the Patient, in determining whether to perform or recommend the Procedures; therefore, the Patient agrees to provide accurate and complete information about the Patient's medical history and conditions. The Patient confirms that the Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

TELEMEDICINE PATIENT CONSENT PURPOSE: The purpose of this "Telemedicine Consent Form" is to get the patient's consent in order to participate in telemedicine appointments.

RECORDS: Telecommunications with patients will not be recorded and stored. Patients' medical information obtained by the diagnosis and analysis can be used anonymously for further improvements in scientific studies.

TELEMEDICINE INFORMATION: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and audio.

ACCESS: The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment.

PATIENT RIGHTS: The patient can withdraw his/her consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

By signing this form, I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices. I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures. I understand that I can be charged the additional fees that my insurance does not cover. I accept that I authorize health care professionals and use telemedicine for my treatment and diagnosis.

Print Name of Patient, Authorized Representative or Responsible Party:

Relationship to Patient:

If patient is unable to sign please provide reason:

Signature of Patient, Authorized Representative or Responsible Party

Date: