GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT AND RELEASE FORM

Patient: _____

Date of Birth: _____

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Magnolia Primary Care, its medical practices and providers including physicians, nurse practitioners, physician assistants, technicians, nurses, and other qualified personnel, including appropriately supervised students to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning a diagnosis or results of treatments, examinations or procedures.

TREATMENT OF MINOR CHILDREN: I understand that minor-aged patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor-aged children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of MAGNOLIA PRIMARY CARE unless I withdraw my consent in writing. I consent to video for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the MAGNOLIA PRIMARY CARE provider for service(s) furnished to me. I authorize MAGNOLIA PRIMARY CARE to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my commercial, governmental or group health insurance plan, directly to MAGNOLIA PRIMARY CARE. I hereby authorize that photocopies of this form to be valid as the original.

SELF-PAY PATIENTS: I understand that if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges incurred at time of service.

PAYMENT AND FINANCIAL GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through MAGNOLIA PRIMARY CARE medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a MAGNOLIA PRIMARY CARE billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with MAGNOLIA PRIMARY CARE's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by a third-party business associate associated with our Electronic Health Records (EHR). I hereby consent to have my payment information collected and stored securely by our EHRs.

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact MAGNOLIA PRIMARY CARE's staff if I am unable to pay my balance. Past Due Accounts of 120 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. MAGNOLIA PRIMARY CARE has a system-wide electronic medical record that is available to caregivers on a "need-to-know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries may automatically be sent to designated MAGNOLIA PRIMARY CARE and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. MAGNOLIA PRIMARY CARE and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

PATIENT PORTAL: If I have provided my e-mail address, I am requesting the ability to access my medical information through the MAGNOLIA PRIMARY CARE online Patient Portal. I hereby consent to use the patient portal provided by MAGNOLIA PRIMARY CARE for accessing my personal health information and communicating with my healthcare

providers. I understand that the patient portal is intended for non-urgent communication, such as scheduling appointments, requesting prescription refills, and viewing my medical records and not for consultation. I understand that the office will respond during business hours and it may take up to 72 hours for a reply. I acknowledge that I am responsible for maintaining the confidentiality of my login credentials and agree not to share them with unauthorized individuals. I understand that the portal should not be used for emergencies or urgent medical issues, and I will contact the office directly or seek immediate medical attention in such cases.

HEALTH INFORMATION EXCHANGE: I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). MAGNOLIA PRIMARY CARE will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

ELECTRONIC PRESCRIBING: I understand that MAGNOLIA PRIMARY CARE medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my MAGNOLIA PRIMARY CARE providers and my pharmacy. I have been informed and understand that MAGNOLIA PRIMARY CARE providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my MAGNOLIA PRIMARY CARE providers to see this health information.

CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that “virtual health” or “telemedicine services” includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information,

including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

CELL PHONES: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from MAGNOLIA PRIMARY CARE, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all MAGNOLIA PRIMARY CARE medical practices and offices provide no facilities for the safekeeping of valuables. I do hereby release MAGNOLIA PRIMARY CARE from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a MAGNOLIA PRIMARY CARE medical practice, office or facility.

CONSENT FOR ELECTRONIC COMMUNICATION: I hereby consent to the use of secure electronic communication by MAGNOLIA PRIMARY CARE and its providers, including pre-visit and post-visit patient engagement tools, to enhance my healthcare experience. I understand that these tools will facilitate efficient communication and management of my health information, ensuring that I receive timely updates and reminders regarding my care. All communications will be conducted within a secure, HIPAA-compliant framework to protect my personal health information. I acknowledge that I can ask questions about these tools at any time and have the right to opt out of using electronic communication tools if I prefer, without impacting the quality of my care.

BEHAVIOR: I agree to use respectful conduct towards all providers and staff. Respectful conduct includes avoiding abusive/foul language, physical threats, disruptive actions and discriminatory behavior. I understand that if I do not conduct myself in a respectful manner I will be dismissed from the practice

OFFICE POLICIES: I have reviewed the office policies and procedures available on the MAGNOLIA PRIMARY CARE website or upon request, and any questions I had have been answered to my satisfaction. I agree to comply with all MAGNOLIA PRIMARY CARE policies.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of MAGNOLIA PRIMARY CARE's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through the use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at MAGNOLIA PRIMARY CARE, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received. I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

_____Signature of Patient or Legal Guardian

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Relationship to Patient if Applicable

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Date/Time of Signing