Franklin Medical GROUP, PC
An affiliate of Saint Mary's Health System

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name: _____ DOB: _____

E-Mail Address: _____
We will not share your e-mail address or use it to transmit medical or clinical information

1) I have been offered or received a copy of Franklin Medical Groups "Notice of Privacy Practices".
2) I give my permission for Franklin Medical Group to contact me at the following numbers and to leave a message on my answering machine or voicemail:

MESSAGES CONCERNING APPOINTMENTS PHONE (___) _____
Home / Mobile / Work (Circle)

MESSAGES CONCERNING MEDICAL INFO PHONE (___) _____
(For example lab or test results) Home / Mobile / Work
(Circle)

I give my permission for Franklin Medical Group to communicate with the following persons regarding my health care:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of Franklin Medical Group.

3) **Assignment of Benefits:** I authorize direct payments to Franklin Medical Group, PC or its designated billing agent for services rendered.

Guarantee of Payment: I will be responsible for payment for all non-covered services. If my health plan does not consider Franklin Medical Group to be a participating provider, I will accept full financial responsibility for payment of incurred charges. I understand that any balance due as a result of being uninsured or under-insured is payable immediately.

Consent for Treatment: I do voluntarily consent to the rendering of such care as the provider and / or medical personnel deem necessary for my health and wellbeing. This consent shall include medical examination and diagnostic testing as well as minor surgical procedures OR I may receive a practice specific consent form. The form may also include the carrying out of orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

4) To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across the Franklin Medical Group, and some other Franklin Medical Group affiliated practices (accessed

only as described in the Notice of Privacy Practices). Our current EMR does not functionally allow us to limit access to your record by blocking it from our Medical Group staff and related practices.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information related to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, the authorized health care providers and professionals listed at www.franklinmedicalgroup.com. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when Franklin Medical Group's EMR no longer exists. Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you have any questions, please do not hesitate to ask us about our EMR.

☐ I choose to opt out and by doing so understand I decline to receive care at Franklin Medical Group.

_____ _____

Patient Signature / Date

Parent or Guardian Signature / Date
If patient is a minor (under age of 18) or has a guardian/conservator, this must be signed by the parent or legal guardian.