PRIMARY
MED CLINIC

Consent for Treatment

I, the undersigned patient (or parent/legal guardian), voluntarily consent to receive medical care, evaluation, and treatment from the healthcare providers at Primary Med Clinic, LLC. This may include routine examinations, diagnostic procedures, laboratory testing, imaging services, administration of medications and injections, minor office-based procedures, and preventive, therapeutic, or follow-up care. I understand that medicine is not an exact science and that no guarantees have been made regarding the outcome of my care. I agree to provide accurate and complete health information, including medical history, medications, and allergies, and I acknowledge that I am financially responsible for all services provided, regardless of insurance coverage. I authorize Primary Med Clinic, LLC to release my medical information as necessary for treatment, payment, and healthcare operations in accordance with HIPAA regulations. I also understand that I have the right to refuse treatment or withdraw my consent at any time, verbally or in writing, as permitted by law.

FINANCIAL RESPONSIBILITY & SELF-PAY AGREEMENT

I hereby authorize payment of medical benefits, otherwise payable to me, to be made directly to Primary Med Clinic, LLC for services rendered. I understand that my insurance policy is a contract between myself and my insurance company, and that Primary Med Clinic, LLC is not a party to that contract. I acknowledge that I am financially responsible for all charges incurred for my care, including any services not covered, denied, or deemed non-medically necessary by my insurance carrier. This includes copayments, deductibles, coinsurance, and any outstanding balances. In the event my insurance company issues payment directly to me, I agree to immediately forward such payment to Primary Med Clinic, LLC. For patients without health insurance (“self-pay”), I understand that I am personally responsible for payment in full at the time services are rendered, unless prior arrangements have been made with the clinic. In the event my account becomes delinquent, I understand that I may be responsible for additional costs associated with collection efforts. This may include reasonable attorney’s fees and court costs, as permitted by law.

PATIENT CONSENT FOR E-PRESCRIBING

E-Prescribing is a service that allows healthcare providers to send prescriptions electronically to your pharmacy, as well as to access certain prescription history and benefit information. This system is designed to improve accuracy, efficiency, and patient safety.

1. I authorize Primary Med Clinic, LLC and its healthcare providers to electronically transmit my prescriptions to the pharmacy of my choice.

2. I understand that my providers may use e-prescribing technology to access and review my medication history from pharmacies, pharmacy benefit managers, and/or insurance companies, in compliance with applicable privacy laws.

3. I acknowledge that this information may include details about medications prescribed by other healthcare providers and filled at other pharmacies.

4. I understand that this information will be used solely for the purpose of providing safe, effective, and coordinated medical care.

5. I understand that I may revoke this consent in writing at any time, though such revocation will not apply to prescriptions or information already transmitted prior to the date of revocation.

PATIENT CONSENT FOR TELEMEDICINE SERVICES

Telemedicine is the use of secure electronic communications—such as video, audio, secure messaging, and electronic data transmission—to provide healthcare services when the patient and provider are in different locations. By signing this consent, I understand that telemedicine allows me to receive medical care remotely and that the provider may rely on the information I provide, including my history, symptoms, and images. I acknowledge the benefits of telemedicine, including convenience, reduced travel, and timely access to care; as well as its limitations, including potential technology failures, delays, or the need for an in-person visit. I understand that my medical information will remain confidential in accordance with applicable privacy laws, although no system can be guaranteed completely secure. I accept responsibility for any applicable copayments, deductibles, coinsurance, or self-pay charges related to telemedicine visits. I also understand that I may withhold or withdraw consent at any time without affecting my right to future care. Finally, I acknowledge that telemedicine is not intended for emergencies, and in such situations, I will call 911 or go to the nearest emergency department**.**

CONSENT FOR PHOTOGRAPHY & VIDEOGRAPHY

I, the undersigned patient (or legal guardian), authorize Primary Med Clinic, LLC and its healthcare providers to photograph or record video of me for medical documentation purposes. I understand that such images may be used to support diagnosis, treatment planning, documentation, and continuity of care, and that any use for educational or training purposes will require my additional written authorization. All photographs and recordings will be treated as part of my medical record, protected under HIPAA and applicable privacy laws, and will not be released or used outside of my care without my separate written consent. I acknowledge that this consent is voluntary and may be refused or revoked at any time without affecting my right to receive care at Primary Med Clinic, LLC. I further understand that images and recordings may be stored in my electronic health record and retained in accordance with legal and clinic policy requirements.

PROHIBITION OF RECORDING

To protect the privacy and confidentiality of patients, visitors, and staff, and to ensure a safe clinical environment, the use of any recording device within Primary Med Clinic, LLC is strictly prohibited without prior written authorization. This policy applies to video, audio, voice recordings, photography, and the use of cell phones, tablets, or any other electronic devices to capture sound or images. I understand that failure to comply with this policy may result in termination of my visit and/or dismissal from the practice.

PRIMARY
MED CLINIC

CLINIC COMMUNICATION

I, the undersigned patient (or legal guardian), give permission to Primary Med Clinic, LLC and its representatives to communicate with me about my care and payment through phone calls, voicemails, text (SMS) messages, email, automated dialing systems, and prerecorded voice messages. These messages may include information about my treatment, test results, prescriptions, referrals, care coordination, insurance, medical records, scheduling, billing, and related matters. I acknowledge that some communications may not be encrypted or secure. I accept the potential risks of unsecure transmission, and consent to the use of automated systems for appointment reminders and healthcare-related messages.

I understand that I may revoke or update this consent at any time by notifying Primary Med Clinic, LLC in writing, except to the extent that action has already been taken in reliance on this consent.

ACKNOWLEDGEMENT & SIGNATURE

By signing below, I acknowledge that I have read, understand, and agree to the above consent for treatment.

Patient Legal Name:_____

Date of Birth: ____ / ____ / _____

Patient/Authorized Representative Signature: _____
Date: ____ / ____ / _____

If signed by an authorized representative:
☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

Printed Name: _____