DMC PRIMARY CARE
Derry Medical Center

GENERAL CONSENT FOR TREATMENT

Patient Name (First and Last): _____ Date of Birth: _____

CONSENT FOR TREATMENT: I hereby voluntarily consent to care, treatment, testing, and all other services performed by healthcare providers, their assistants and other staff members at DMC Primary Care (DMC). I acknowledge that this consent is applicable to all locations. I understand that I have the right to refuse to consent to any proposed care, testing, treatment, or procedure. I also understand that I have the right to ask questions and discuss my concerns with my healthcare provider. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination, and/or treatment at DMC.

ACKNOWLEDGMENT: I understand that I am required to sign this consent annually or whenever DMC deems it necessary. I understand that I may revoke this consent at any time by notifying DMC writing, but that my revocation of consent will result in me no longer being able to receive care or treatment from DMC. I further understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between DMC and me, and I agree to actively participate and to accept my role and responsibilities with regard to my healthcare decisions.

TELEMEDICINE: I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

STUDENT PARTICIPATION: I understand that DMC occasionally participates in the education of students in healthcare. I can decline their participation in my care at any time.

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RECORDING: 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.

RELEASE OF INFORMATION: I understand that protected health information (PHI) typically includes information about my symptoms and health condition, results of physical examinations and diagnostic tests, plans for future care and treatment, and demographic and photographic identifiers. Such individually identifiable information about me will be used, shared, or disclosed only for the purpose of treatment, payment, and healthcare operations, or as required by law. Otherwise, my PHI will not be inspected or released without my specific authorization except in certain circumstances, which are outlined in DMC's Notice of Privacy Practices. I understand that the DMC Notice of Privacy Practices is publicly posted in a clear and prominent location in all DMC facilities and is available on the DMC website. The Notice of Privacy Practices outlines how my PHI may be used and disclosed, and details my rights to access, limit, obtain, and correct my medical and health care information, and my right to make a complaint if I feel my privacy rights have been violated. I understand that I may request a written copy of the Notice of Privacy Practices at any time.

COMMUNCATION: I hereby consent to provide my telephone number(s) so that representatives from DMC may contact me in any manner (manually placing a call, using an automatic telephone dialing system or an artificial or prerecorded voice, texting, or e-mailing), regarding any matter, including my medical treatment, prescriptions, insurance eligibility and coverage, scheduling, billing or collection matters. I understand that I can change my preference at any time.

PERSONAL BELONGINGS: I understand that DMC takes steps to ensure that the waiting room and other areas of the practice are safeguarded. However, I acknowledge that I am solely responsible for any personal belongings that I bring with me to my appointment, including jewelry and other valuables.

_____ _____

Signature of Patient/Legal Representative: Date and Time:

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient