SHORE | PHYSICIANS GROUP SM

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Patient name (print): _____ **Date of Birth:** _____

CONSENT FORM FOR THE AUTHORIZATION OF TREATMENT & RELEASE OF INFORMATION

Consent for Medical / Surgical / Urgent Care

I hereby authorize Shore Physicians Group, PC to provide initial and ongoing medical / surgical treatment that is necessary and reasonable as based on acceptable standards of care for my wellness and the treatment of my physical condition.
I consent to examinations, blood tests, laboratory procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician, and their associates and assistants, or rendered by facility personnel under the instructions, orders and direction of such physician(s).

Consent for Telehealth/Telemedicine Services

Telehealth/Telemedicine involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that: I will be informed of any other people who are present at either end of the telehealth/telemedicine encounter and have the right to exclude anyone from either location. All confidentiality protections required by law or regulation will apply to my care. I have the right to refuse or stop participation in telehealth/telemedicine services at any time and request alternative services such as an in-person appointment. However, I understand that the equivalent in-person services might not be available at the same location as the teleheath/telemedicine services. If I do not want to receive health care services by telehealth/telemedicine, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled. If an emergency occurs during a telehealth/telemedicine encounter, 911 will be called and your Provider will stay on the video until help arrives. Potential risks include, but may not be limited to, delays due to complications or difficulties related to connectivity or equipment, in rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making, delays in evaluation could occur due to deficiencies or failures of the equipment and although highly unlikely, security protocols can fail, causing a breach of privacy.

Authorization to Release Medical Information

I hereby authorize Shore Physicians Group, PC to release information obtained in the course of my medical / surgical / urgent care to my insurance carrier and other providers of healthcare and healthcare organizations involved in my care. In the event of an employee blood or body fluid exposure I authorize Shore Medical Center to release pertinent testing for the treatment of the employee. I also authorize Shore Physicians Group to receive my medication history. I agree, in order for Shore Physicians Group to service my account to collect any amounts owed, Shore Physicians Group and its affiliates, may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Shore Physicians Group and its affiliates, may also contact me by sending text messages or emails, using any email address I provide.

Assignment of Benefits

I hereby assign all medical / surgical / urgent care benefits to which I am entitled, including major medical benefits, Medicare, private insurance and any other health plans, to Shore Physicians Group, PC. A photocopy of this assignment is to be considered as valid as the original.
I understand that I am financially responsible for all costs not covered by my insurance plan(s). This includes but not limited to co-pays, coinsurances, deductibles, and non-covered procedures and / or diagnoses. I understand that if my insurance requires a referral for me to receive treatment here, that is my responsibility to obtain that referral from my primary care physician. I also understand that I am expected to make payment for previous balances or balances sent to collections prior to my office visit. If I am unable to pay my balance in full, I understand that I can speak to the office manager to set up a payment plan.

I understand that Shore Physicians Group reserves the right to impose a fee for un cancelled (failure to show) appointments.

I authorize the release of information including the diagnosis, records & examinations rendered to me as well as claims information, to the persons listed below:

Name: _____ **Relationship:** _____

Phone number: _____

Name: _____ **Relationship:** _____

Phone number: _____

Patient or Legal Representative Signature: _____**Date:** _____

Relationship to Patient: _____