Adult Patient Authorization Form

Patient's Legal Name:____ **Date of Birth:** __________
First MI Last (preferred) MM/DD/YYYY

Mailing Address:____
Street City State Zip

E-mail Address: ____

Consent for Treatment: I (print name) ______________________________ consent to routine medical treatment and/or evaluation including but not limited to laboratory and x-ray examinations. I understand that separate consents will be requested for certain special procedures. I also understand I have the right to refuse any proposed procedure or treatment.

Signature: ____ **Date:** _____________

Preferred Telephone Number: ☐ Home ☐ Cell ☐ Work	**Okay to leave a <u>detailed</u> voice message?** *May contain medical and/or prescription information*
Home: (_______) _________ - ___________	☐ Yes ☐ No
Cell: (_______) _________ - ___________	☐ Yes ☐ No
Text message communication: InterMed utilizes text messaging to better serve patients in a convenient manner including appointment reminders, important visit instructions and non-specific clinical information. Message and data rates may apply. I understand I may revoke my election to receive texts by reaching out to InterMed at any time. Please see other side of document for additional information.	☐ I consent to receive text messages ☐ I do <u>**not**</u> consent to receive text messages
Work: (_______) _________ - ___________	☐ Yes ☐ No

Primary Coverage	Insurance Carrier:	Subscriber ID:	Group #:
Secondary Coverage	Insurance Carrier:	Subscriber ID:	Group #:

Emergency Contact Information: Please specify your preference for communication should an emergency arise. If the person specified should also receive authorization to communicate on your behalf, please indicate in the section below.

Emergency Contact Name:________________________________Relationship:_______________________
First Last

Emergency Telephone**:** (_______)________________(______)____________________(_____) ______________
Home *Work* *Cell*

Communication Authorization: You may specify up to three individuals authorized to receive routine <u>verbal</u> communication about your healthcare, other than mental health treatment. Disclosure of mental health treatment status requires execution of InterMed's release of information. Please provide their <u>first and last names</u>, and the information you authorize to be shared with each individual.

Name:	☐ Prescription Request ☐ Referral Request	☐ Request a new Appointment ☐ Request Changes to Appointment	☐ Medical inquiries/status updates
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MyInterMed Patient Portal Enrollment: MyInterMed is a secure, web-based platform that allows you and your care team bi-directional communication about your non-urgent matters. You can also view your medical record, upcoming appointments, lab results, request prescription refills, & more. Usage of the portal is restricted to communication regarding your care and is not to be used to communicate about the care of others. Enrollment is free.

- ☐ Enroll me
- ☐ Do **not** enroll me
- ☐ Currently Enrolled

Carequality/Commonwell Health: To facilitate primary care and communication with other healthcare practitioners or facilities who have been or may become involved in my care both within and outside the State of Maine I agree to be enrolled in Carequality and Commonwell Health. These are tools that InterMed uses to exchange data with other providers in real-time including pertinent clinical information to assist in the delivery of care, especially in emergency situations; to clinical and non-clinical personnel who may now or in the future become involved in both the management and transition of my care between hospitals, medical practices, other health care facilities and home including care coordination and case management services; and for other lawful functions

- ☐ Enroll me
- ☐ Do **not** enroll me
- ☐ Currently Enrolled

Satisfaction Surveys: InterMed seeks patient feedback after each visit to continuously improve the patient experience. These surveys may be conducted via automated dialing service and/or an artificial or prerecorded voice.

- ☐ I consent to receive surveys
- ☐ I do **not** consent to receive surveys

Text Messaging: Text messaging does not use encryption, and there is some risk when information is sent by text message. InterMed has chosen specific non-sensitive clinical information that may be sent to an individual who opts into the service. Example texts could include, but are not limited to, a notification that your labs or imaging were normal, alerts that a result has been posted to your portal, or a confirmation that a refill request has been sent to your pharmacy. If at any time you wish to opt out of receiving non-sensitive clinical information by text, you may do so.

This authorization should be updated every 12 months. This authorization will remain current until an updated version is received, or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time. Revocation will not cover information that has already been released. **I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above.**

____ __________________
Patient/ Legal Guardian Signature **Date**

Reviewed and updated by (Employee Initials):

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment
- Follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received InterMed's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that InterMed has the right to change its Notice of Privacy Practices from time to time and that I may contact InterMed at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____________________________________ DOB: _______________

Signature ____

Relationship to Patient____

Date ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: