Global Consent (2024)

CONSENT TO TREAT

I hereby authorize and consent to the performance of physical examination and treatment by a physician assistant (PA), nurse practitioner (NP), or physician from *Mason-Dixon Mobile Medicine*. This consent is given in advance and includes permission to review my prescription history with the SureScripts prescription database and to exchange protected health information (PHI) required to facilitate in-home diagnostic services (imaging, lab, home health, etc.) I understand that *Mason-Dixon Mobile Medicine* is not a 24-hour emergency service and has no guaranteed availability for emergencies. I understand that in the event of an emergency or urgent health condition, I should seek immediate treatment at an appropriate healthcare facility. Under no circumstances will I postpone care or evaluation of an urgent or emergency condition waiting for a visit or return communication from providers at *Mason-Dixon Mobile Medicine*.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of *Mason-Dixon Mobile Medicine's* Notice of Privacy Practices (NPP). I understand the NPP provides information about how protected health information about me may be used and disclosed in providing care to me and receiving payment for that care. I understand that the terms of the notice may change as allowed by law. I understand that I can review the NPP at *Mason-Dixon Mobile Medicine*'s website.

HEALTH INSURANCE ACKNOWLEDGMENT

I hereby authorize Medicare and other insurance payers to make payments to *Mason-Dixon Mobile Medicine* on my behalf for services furnished. I authorize any holder of medical information about me to release to my Insurance Carrier or its agents, for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I acknowledge I am fully responsible for services provided by *Mason-Dixon Mobile Medicine*. I accept financial responsibility for all charges billed and agree to pay all such charges. Bills are payable and become due on statement presentation. I further acknowledge that if payment arrangements are not made in a timely fashion, the amount due may be subject to collection. Accounts sent for collection will incur additional fees, including collection costs, interest, and attorney's fees of 35% of the balance due.

SMS TEXT MESSAGING TERMS OF SERVICE

I may elect to opt-in to exchange SMS text messages with *Mason-Dixon Mobile Medicine*. To opt-in, I may text the word START to 240-397-6723 and should receive the SMS messaging terms of service in response to the START text. I will contact the office for questions.

INCORPORATION OF GENERAL PRACTICE INFORMATION

I acknowledge that the General Information form is considered a part of this Global Consent. I understand the contents of the General Information form may change from time to time, and the latest version is always available on the practice website.

PATIENT RESPONSIBILITY ACKNOWLEDGMENT

I understand that, as a patient of *Mason-Dixon Mobile Medicine*, I have certain responsibilities to assist *Mason-Dixon Mobile Medicine* in providing high-quality care. This includes the responsibility to fully disclose all symptoms, medications, conditions, and other relevant information to assist my care provider

in diagnosing, treating, and/or referring me for specialized care, as well as my responsibility to cooperate with and follow all recommendations and instructions in connection with treatment I elect to receive from *Mason-Dixon Mobile Medicine*.

In consideration of receiving medical services and treatment from *Mason-Dixon Mobile Medicine*, I hereby, for myself and for my heirs, executors, administrators, and assigns, release from liability and waive my right to sue *Mason-Dixon Mobile Medicine*, its employees, officers, volunteers, and agents from any and all claims resulting in any physical injury, illness (including death), pain, suffering, worsening of condition, or economic loss I may suffer as a result of my failure to disclose relevant medical information and/or from my failure to follow the instructions of my care provider in accordance with the treatment plan I elect to receive from said provider.

I acknowledge that nothing in this "Patient Responsibility Acknowledgement" abridges, intends to abridge, or otherwise affects my right to make all decisions about my own medical care. I understand that I have the right to make all decisions about the provision, withholding, or withdrawal of any specific medical treatment or any course of treatment. I have the right to choose to have a type of medical treatment that is different than what my care provider recommends or to refuse treatment, even if my care provider says I will become sicker or die without the treatment.

I acknowledge that my obligation to follow my care provider's recommendations is limited only to those situations in which I agree with my care provider on the course of treatment being rendered. In the event I elect to choose a type of medical treatment that is different than what my *Mason-Dixon Mobile Medicine* care provider recommends, in the event I choose to receive a second opinion and/or medical treatment from an alternate provider that is not *Mason-Dixon Mobile Medicine*, or in the event I elect to refuse treatment, *Mason-Dixon Mobile Medicine* assumes no responsibility and/or liability for physical injury, illness (including death), pain, suffering, worsening of condition, or economic loss I may suffer as a result.

I acknowledge nothing in this "Patient Responsibility Acknowledgment" relieves or is intended to relieve *Mason-Dixon Mobile Medicine* of any obligations it may have under state, local, federal, or regulatory law, nor does this "Patient Responsibility Acknowledgment" relieve or purport to relieve *Mason-Dixon Mobile Medicine* of any legal or ethical obligation it may have to render care and/or to render care to the standard and in the manner required by the Maryland Board of Physicians, the Maryland Board of Nursing, or any other ethical or regulatory organization which exercises oversight of *Mason-Dixon Mobile Medicine*'s practices.

_____ _____
Patient / Legal Representative Signature Relationship to Patient

_____ _____
Printed Name of Patient Date