Austin
HAND TO SHOULDER
CENTER

Consent To Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing and treatments as directed by my physician or his/her designee. I understand that Austin Hand to Shoulder Center includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various education programs. I understand that I may request and receive information on the specific affiliation(s) or any particular healthcare provider I encounter during my care.

I understand that this consent to treat will be valid for each visit I make to the Austin Hand to Shoulder Center until revoked by me in writing.

I acknowledge and consent to see a physician or other practitioner via telemedicine. I understand that my eligibility to receive a visit via telemedicine is based on the physician's medical judgment that it is appropriate, and the quality of care will not be diminished by the use of telemedicine. If telemedicine is appropriate for my encounter, I will communicate with the physician or other provider through advanced communication technology using live video and audio feed. I understand that my healthcare provider or I may terminate the telemedicine visit at any time, including if the provider or I feel an in-person visit is necessary. I will have telemedicine equipment, personnel, potential risks, and alternatives to telemedicine explained to me prior to a telemedicine visit. I understand that any complaint may be filed with the Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018.

2. Consent to Release Information

I acknowledge that Austin Hand to Shoulder Center may release my protected health information as necessary for treatment, payment and healthcare operations and acknowledge that Austin Hand to Shoulder Center Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use alcohol or drugs, prescriptions and laboratory test results, including HIV and diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure, I may be required to pay the entire cost of my medical treatment provided by Austin Hand to Shoulder Center.

I acknowledge that and consent to allow Austin Hand to Shoulder Center to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health disclosed

through health information exchange systems by providing the signed Austin Hand to Shoulder Center "opt out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Austin Hand to Shoulder Center all rights, title and interest in payments form third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Austin Hand to Shoulder Center are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuits filed, I agree to pay all patient charges, reasonable attorney fees and collections expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Austin Hand to Shoulder Center on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-Ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Austin Hand to Shoulder Center or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that Austin Hand to Shoulder Center will retain ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Provider

I understand that Texas Law provides, and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

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8. Notice of Privacy Practice

I acknowledge that receipt of the "Notice of Privacy Practices" from Austin Hand to Shoulder Center.

By signing, I agree to the terms of this document, which I have read, and that the opportunity to ask questions about. If the patient is a minor (or otherwise unable to consent), I have the authority and am signing this consent on the patient's behalf.

Patient Printed Name	Patient Date of Birth
Patient/Responsible Party Signature	Date
Witness	Date