New Patient Consent Form

Last Name_____ **First Name**_____

Date of Birth_____ **Social Security #** _____

Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the providers of Unified Health Associates, their staff and designees, as may in their professional judgement, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

I understand that the providers, staff and prospective patients of Unified Health Associates will abide by the published Patient Rights and Responsibilities.

By signing below, I confirm that I have reviewed the published Patient Rights and Responsibilities, and am willing and able, to abide by my responsibilities.

Assignment of Benefits, Authorization and Release of Information

I hereby authorize the release of medical information to my insurance company(s) and assign benefits otherwise payable to me to Unified Health Associates to bill my health insurance for the care that is provided to me. I request that payment of authorized benefits be made directly on my behalf to Unified Health Associates for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financial Administration, and its agents, to determine benefits payable for related services.

Protected Health Information

My “protected health information” means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical and mental health conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Unified Health Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Unified Health Associates, including the sharing of my protected health information externally with other providers and pharmacies in order to provide medical care.

I understand that I have the right to request a restriction as to how my protected health information is used, or disclosed, to carry out treatment, payment, or healthcare operations of the practice. Unified Health Associates is not required to agree to the restrictions that I may request. However, if Unified Health Associates agrees to a restriction that I request, the restriction is binding on all of the providers, and the staff of Unified Health Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that the providers, and the staff of Unified Health Associates have acted in reliance on this consent.

By signing below, I confirm that I have been provided with and understand the Unified Health Associates Notice of Privacy Practices, which provides a more complete description of the Protected health Information.

Electronic Medical Record Data Sharing

I authorize and grant Unified Health Associates consent to view my universal health record, outside health records, and prescription history information, and to import pharmacy or health record information through Surescripts, Cerner, or other electronic transmission methods as applicable.

I authorize and grant Unified Health Associates consent to electronically share my immunization information with the State's immunization registries.

I acknowledge that I will not hold Unified Health Associates or its staff responsible for any damages associated with third party data breaches or cyberattacks.

AI Scribe

Unified Health Associates providers may on occasion use Artificial Intelligence software that assists with patient encounters by generating clinical notes based on our visit encounters and conversations. The software will listen to the conversation and generate a summary in the form of a clinical note. The software is HIPAA compliant to ensure data is secure and protected. The use of the software is intended to allow the provider to focus more on the patient and less on documentation.

By signing below, you consent to the use of the software to allow our staff to have more dedicated time with you during the visit.

Notice of Patient Privacy, Rights, and Responsibilities

I acknowledge that I have received and reviewed a copy of the Unified Health Associates Patient Privacy and Patient Rights and Responsibilities document respectively.

Notice of Surveillance & Monitoring

I acknowledge that I have been informed that while I am a patient at Unified Health Associates that I will be under camera surveillance for my safety and protection. Surveillance is only video recording, and no audio is included.

Patient or Representative Signature Page

By signing this agreement, I acknowledge that I have read, understand, and agree to the terms of the above policy in its entirety.

Signature of Individual or Representative_____

Date_____

NOTICE AND ACKNOWLEDGMENT
OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated.
by the Medical Board of California.

To check up on a license or
to file a complaint, go to
www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Representative's Name and
Relationship

_____

Patient's Representative's Signature

Original to be maintained in patient's medical records.