Steward
MEDICAL GROUP

* 314004512w2017 A-Consent

GENERAL CONSENT FOR TREATMENT

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to the rendering of medical care, treatment and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment .

I understand that medical diagnosis and treatment may involve substantial risk. I understand that absent emergency or extraordinary circumstances, major therapeutic and diagnostic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction with my physician or other health care professional and I have consented to such procedure . I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic treatment performed on me at the hospital .

Further, I understand and agree that medical, nursing, and other health care personnel in training may participate in my care and treatment as part of their education and training unless I request otherwise. I understand that I have the right to refuse or withhold my consent to any proposed diagnostic or therapeutic procedure . I have been afforded the opportunity to set forth below any limitation s to the general consent I have granted herein .

USE AND RELEASE OF INFORMATION:

I understand that Steward Medical Group will keep records that contain my medical, personal, and other information related to my diagnosis, care, and treatment in electronic, paper, and other forms. I understand that Steward Medical Group may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to other health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process insurance claims, for utilization and review, or for billing and collection purposes, as necessary to obtain payment); or (3) for the health care operations of Steward Medical Group or another health care provider that has had a relationship with me (quality assessment, training programs, planning, etc.). This information may include genetic test results or other information as needed for these purposes.

TELEMEDICINE:

I understand that Steward Medical Group may use telemedicine during the course of my care and treatment . Telemedicine uses audio and video equipment to permit a two- way, real- time, interactive communication between a patient and a physician or other practitioner who may be located at a distant site. The information gathered during a telemedicine encounter will be maintained in my medical record, and privacy and confidentiality of my medical information will be maintained at all times . The hospital will not record the actual audio or video transmission unless otherwise specified by my physician or practitioner . I understand that I have the right to withdraw my consent for telemedicine at any time without affecting my right to future care or treatment. I also understand that alternative methods of care may be available to me, and I may choose other options at any time.

ASSIGNMENTS OF BENEFITS:

I hereby assign to Steward Medical Group the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Steward Medical Group. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

FINANCIAL RESPONSIBILITY:

I understand that insurance may not pay the full amount of all my charges and I acknowledge that I am financial ly responsible and agree to pay my bill for non-covered services, as well as any deductibles, coinsurance or any amounts in excess of insurance benefits . If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

SIGNATURE:

My signature below constitutes my acknowledgement that I have read and understand the above information, that any questions I have asked have been satisfactorily answered, and that I agree to this consent of treatment as described herein.

Patient's Signature: _____ Date: ____/____/____

Personal Representative: _____ Relationship to Patient: _____ Date: ____/____/____

Witness and/or Interpreter: _____ Date: ____/____/____

Steward
MEDICAL GROUP

ACKNOWLEDGEMENT OF PRIVACY RIGHTS & PRACTICES AND CONSENT FOR COI * 314004512w2017 A-Consent

CONSENT TO USE OF TEXT MESSAGES

I consent to the receipt of text messages from Steward Medical Group and/or its agents on any phone number I provide. If I do not wish to continue receiving text messages, I can discontinue this service at any time.

Initials: _____ Cell Phone Number for Texting: (_____) _____-_____

CONSENT FOR PAYMENT & COLLECTION COMMUNICATIONS:

I agree that Steward Medical Group and its agents, including debt collectors, may contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message, even if I am charged for the call or message, for the purpose of servicing my account and collecting amounts due. I agree that such automated calls may be made to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service) I have provided previously or may provide in the future in connection with my account, unless I have requested confidential communications from Steward Medical Group and its agents or a restriction on the disclosure of my healthcare information in accordance with the Notice of Privacy Practices and Steward Medical Group has agreed to such request. With this consent, I waive any claim I may have against Steward Medical Group and/or its agents, including debt collectors, for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. I also agree that this provision applies to th e use of text messaging .

I understand there is a risk of a third-party accessing my health information when communicated over these media. I understand that I am not required to consent to these types of communications and a decision not to sign this consent authorization will not affect my health care in any way. If I prefer not to consent to these communication methods (opt out of receiving prerecorded telephone and text messages), I understand that Steward Medical Group will continue to use U.S. Mail or regular telephone messaging to communicate with me. I have read this consent and agree that Steward Medical Group may contact me as described above.

Patient's Signature: _____ Date: ____/____/____

NOTICE OF PRIVACY RIGHTS & PRACTICES – ACKNOWLEDGEMENT STATEMENT:

I acknowledge that I have received a copy of the Steward Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes the ways in which Steward Medical Group may use and disclose my healthcare information for treatment, payment, and healthcare operations . I understand that I may contact the Privacy Officer identified in the Notice of Privacy Practices if I have questions or a complaint.

Patient's Signature: _____ Date: ____/____/____
(or signature of parent, representative/guardian if applicable)

Staff Use Only:
If unable to obtain acknowledgment, describe your attempt to obtain it and why you were unable to do so:

Reason: _____

Staff Signature: _____ Initials: _____ Date: ____/____/____

TEST, Test (id #103550403, dob: 01/01/1901)

TEST, TEST 01/01/01 #103550403

* 514004511w2017 A-FormLett

Steward
MEDICAL GROUP

GSM_SMG NOVACARE MEDICAL
401 N BEDFORD STEAST BRIDGEWATER, MA 02333-1147
Phone: 781-375-3150, Fax: 781-375-3146

Missed Appointment Policy

Steward Medical Group is dedicated to improving the health of our patients and their families. We understand that situations arise in which you must cancel your appointment. In order to provide you with the best possible care, your clinical team needs to prepare for your visit.

If for any reason you are unable to make your scheduled appointment, please be sure to inform the office as soon as possible so that we may re-schedule your appointment promptly and that another patient waiting to be seen may be offered your visit slot.

It is requested that you provide at least 24 hours' notice prior to your scheduled visit. If you schedule an appointment within 24 hours, including same day appointments, you will be charged the no show fee if you do not arrive for the visit.

Cancellations received with less than 24 hours' notice, do not allow us the appropriate time to offer the slot to other patients who are waiting to be seen.

Patients who fail to show for their office visit without calling to cancel will be considered a Missed Appointment and subject to a $25.00 fee.

Patients who fail to show for their Procedure without calling to cancel will be subject to a $50.00 fee.

Patients who have three (3) or more missed appointments in a 12 month period, may be terminated from the practice.

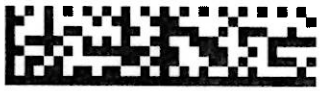
The Missed Appointment fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Questions about cancellation and missed appointment fees should be directed to the practice by calling 781-375-3150. If you feel you have received a missed appointment letter in error, please contact the Practice Manager immediately.

Please sign that you have read, understand and agree to this Missed Appointment Policy.

TEST TEST	01/01/1901	08/30/2023
Patient Name	**Date of Birth**	**Date**

Signature of TEST TEST or Patient Representative



Steward
MEDICAL GROUP

Updating Confidential Communications

Patient Name:_____ Date of Birth: ____/____/____

Use this section to **AUTHORIZE** others who may contact Steward Medical Group (SMG) to obtain PHI and to communicate with our practices regarding the patient above. For example, spouse, children, parent, friends, etc.

Authorized User #1: _____ Date of Birth: ____/____/____

Relationship to You: _____ Phone # ( ) _____ - _____

Authorized User #2: _____ Date of Birth: ____/____/____

Relationship to You: _____ Phone # ( ) _____ - _____

If more than 2 Authorized Users – complete another form.

Use this section to request that SMG **DOES NOT** disclose my PHI with the following individuals:

Unauthorized User #1: _____ Date of Birth: ____/____/____

Relationship to You: _____ Phone # ( ) _____ - _____

Unauthorized User #2: _____ Date of Birth: ____/____/____

Relationship to You: _____ Phone # ( ) _____ - _____

Patient Signature:_____ **Date:** ____/____/____

Do you **Authorize** Steward Medical Group (SMG) to leave a detailed message on your answering machine?

Select one of the following options:

__ I **AUTHORIZE** Steward Medical Group (SMG) to leave any verbal messages on my answering machine.

__ I **DO NOT** Authorize Steward Medical Group (SMG) to leave verbal messages on my answering machine.

Patient Signature:_____ **Date:** ____/____/____

FOR SMG USE ONLY

Request rec'd on: ____/____/____ □ Request updated in Athena Request updated by: _____

Steward
MEDICAL GROUP

COMMONWELL/CAREQUALITY PATIENT RECORD SHARING CONSENT FORM

Steward Medical Group ("SMG") shares patient medical records in accordance with SMG's Notice of Privacy Practices, including for patient care and treatment purposes. In support of patient care and treatment, SMG is allowing patients to elect to have their medical records shared through the CommonWell and Carequality platforms.

By signing below, you are consenting to participating in the CommonWell and Carequality platforms. Your participation will allow health care providers at SMG and other participating facilities/offices to share and exchange your medical records for your care and treatment. Also by signing below, you are consenting to the sharing of the following categories of medical records through the CommonWell and Carequality platforms for purposes of your care and treatment:

- Mental/Behavioral Health or Disability Services
- HIV/AIDS
- Alcohol and/or Substance Abuse Treatment
- Genetic Testing
- Communications with a Social Worker
- Rape/Sexual Assault Victim's Counseling
- Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability
- Communicable Diseases/Sexually Transmitted Diseases (STDs)
- Domestic Violence Victim's Counseling
- Reproductive Health

I understand that I may revoke my consent by sending written notice of revocation to SMG.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____