Name _____ **MRN#** _____

I. Consent to Treatment

I consent to the examinations, treatments and procedures that may be performed during my affiliation with Diagnostic Clinic. If I am the representative/responsible party for another person or a minor, I also provide such authorization. This will include radiological examinations, laboratory procedures, medical and non-invasive treatments or procedures, or other medical or medically related services rendered to the patient under the general and special instructions of the physicians or allied health provider(s) of Diagnostic Clinic. ***Additional informed consent may be required for certain procedures.***

Initial _____

II. Code of Conduct

I have read and understand DCMG Organizations **Patient Code of Conduct.** Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within DCMG facilities. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non verbal remarks. No hostile communication or gestures regarding an individuals' race, ethnicity, language or sexuality is permitted within DCMG facilities. Appropriate attire, shoes must be worn as well as nudity and/or inappropriate exhibition and/or exposure will not be tolerated and removal from the premises will be requested.

Initial _____

III. Consent to Receive Communications via E-Mail, Telephone Calls, Text Messages and Postcards

I give my express consent to receive communications, from DCMG via e-mails, telephone calls to my cell phone or landline (including voicemail messages on these lines) text messages, and/or postcards at the telephone number and/or addresses that I have provided to DCMG. Such communication may include, but are not limited to: written or verbal messages reminding me of my appointments, account balances, preventative care recommendations, instructions on how to electronically access my summary of care record following my evaluations, and reminders regarding DCMG policies and procedures. I realize that any time I may opt out of receiving communications from DCMG through the channels described above by following the opt out directions contained in the texts, verbal automated messages and/or by calling DCMG. I expressly acknowledge and agree that this consent includes communications that may contain Protected Health Information ("PHI") as described in DCMG's Notice of Privacy Practices.

By selecting this consent, you authorize DCMG to release PHI to you in the manner described above and agree that you are solely responsible and liable for the confidentiality and security of the street or email address or telephone numbers (cell and/or landline) you provide, the security of the devices upon which you view the PHI, and the risks inherent in using electronic communications, including risks that these communications can be intercepted, altered, forwarded or used without authorization or detection. You have the right to designate a different email address or telephone number at any time, and you should do so if you believe that the address/telephone number you are providing today is no longer secure or valid. You understand that failing to update your e-mail address/telephone number may result in a delay or failure of notification of important information and/or the possible release of PHI to an unintended recipient.

Initial _____

IV Lifetime Authorization – Medicare Certification for Payment

I certify that the information given by me in applying for payment under Titles XVIII of the Social Security Act (i.e., Medicare) is accurate and correct. I authorize any holder of medical or other information about myself, or the patient I represent to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my or the represented patient's behalf. I hereby assign the benefits payable for physician services to the physician or organization furnishing the services, and hereby authorize such physician or organization to submit a claim to Medicare for payment.

Initial _____

V. Assignment of Insurance or Third Party Benefits

I authorize direct payment to Diagnostic Clinic of any insurance, managed care, self-insured plan, or other third party benefits or state disability benefits otherwise payable to or on behalf of myself or the patient for services rendered, and assign to Diagnostic Clinic, for application to patient's account, all such benefits, payable at a rate not to exceed Diagnostic Clinic's regular rates and charges. I understand that I, or the patient I represent, will remain responsible for all charges or applicable co-payments not covered in whole or in part by the payor, subject to applicable law.

Initial _____

VI. Financial Responsibility Agreement

By signing this agreement, whether as a patient, representative, or guarantor, I fully understand, acknowledge, and agree to each of the following:

- I will be fully financially responsible for any and all services rendered by Diagnostic Clinic and its staff, ***whether covered or not covered*** by insurance, an employee benefit program, Medicare, Medicaid, or HMO.
- I agree to pay any additional account balances in full at the time of billing statement receipt
- I agree to pay any additional account balances in full at the time of my next visit even if I have not yet received a billing statement.
- I certify that I have read the foregoing, and I am the patient, guarantor, or the patient's representative duly authorized to execute this Agreement and accept its terms.

_____ _____ _____

Signature of Patient/Guarantor/Representative **Relationship if not self** **Date**