Phone Number: 770-812-9666

Consent for Treatment of Dependent Adults and Minors

I am the parent or legal guardian/advocate of _____, whose date of birth is_____. I authorize Tanner Medical Group to provide medical/mental health care to my dependent, including but not limited to, diagnostic examinations (including radiology and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures and mental health counseling. I understand that should my dependent need more invasive diagnostic or surgical procedures, I will be notified prior to such medical care being initiated. I understand that I may be seen by either a physician, physician's assistant, or a nurse practitioner at Tanner Medical Group. I understand that students under the direction of a physician may be involved in patient care. Please provide copy of Power of Attorney for Dependent adults.

I understand that TMG participates in a secure Health Information Exchange (HIE). The HIE supports integrated system patient care initiative by allowing physicians and healthcare providers to share and access patients' health information through an HIE for treatment, payment, and health care operations purposes. I understand that I have a right to opt out of having my information available in the HIE by signing an Opt-Out form**.**

I understand that as part of the HIE, I have the right to elect to participate in Tanner MyChart Patient Portal to obtain secure access to my personal patient information.

The following individuals have my permission to bring my child to the office for routine medical care.

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

Guarantor Financial Agreement:

Financial Agreement: I acknowledge, that as a courtesy, the practice may bill my insurance company for services provided to me. I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand that I may be asked to pay for services at the time services are received. I understand there is a fee for returned checks.

Third Party Collection: I acknowledge the practice may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Workers Compensation: If your injury is work−related, we will need to verify coverage and request the case number and carrier name prior to your visit to bill the worker's compensation insurance company. Otherwise, you will be responsible for all charges.

Assignment of Benefits: I hereby assign to the practice any insurance or other third-party benefits available for health care services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare or Medicaid program.

Guarantor/Responsible Party Name: _____

Signature: _____ Date: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations:

_____ (initial here) I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes. I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to receive phone calls, emails or text messages:

By signing this form, I expressly consent and authorize Tanner Medical Group (TMG) and its affiliates and agents, including any collection agency or debt collector hired by TMG or any of their agents to communicate with me for any reason, by phone, email or text message, including, but not limited to the purposes of:

- Past and future medical services, including but not limited to appointment and prescription reminders, updates and instructions for your visit and other health related matters
- Billing and collection services
- Informational and marketing purposes, including but not limited to: issues involving health and wellness matters
- Communications related to patient satisfaction surveys

This communication may be made using an automatic telephone or texting/bi-directional texting system or an artificial or prerecorded voice at the telephone number(s) I provided to TMG and its affiliates and agents. With this consent, I waive any claim I may have under federal or state law, including but not limited to the Telephone Consumer Protection Act 477 U.S.C 227 and its implementing regulations, against TMG/TMC and any physicians or physician groups associated with my care and any of their agents, representatives or business associates, including their billing service providers and any potential debt collectors, for the making of such calls and text messages.

_____ (initial here) I understand that consent to receive text automated technology is not required to receive healthcare services.

_____ (initial here) I understand that message/data rates may apply to messages sent to my cell phone and that I may receive multiple texts per month.

_____ (initial here) I understand that I may opt-out of receiving these communications from TMG, and its affiliates and agents, at any time by calling 770-812-9666 or by replying to a text with "Unsubscribe"

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

Notice of Privacy Practice/clinics:

_____ (initial here) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

To better protect your privacy, the following person(s) may discuss and/or release protected health information to include:

[ ] Test Results
[ ] Appointment Information
[ ] Rx Requests and Information
[ ] Billing Account Information
[ ] Test Preparation Information and Patient Instructions
[ ] Treatment Plan Information

1. Name: _____ Relationship: _____

   Phone Number: _____ DOB_____

2. Name: _____ Relationship: _____

   Phone Number: _____ DOB_____

Patient Name: _____

Signature: _____ Date: _____