Patient Name: _____
Patient DOB: _____

**GENERAL CONSENT FOR TREATMENT**

**Consent for Treatment**: The undersigned authorizes and consents to MEA and its physicians furnishing medical and surgical treatment that the Patient's· physicians consider necessary and proper in the treatment of the Patient. This treatment may require diagnostic procedures, including but not limited to, laboratory tests, drawing blood for those tests, x-ray/imaging, and electrocardiograms.

I understand that if the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. MEA does not become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee.

I understand that being seen for a "Wellness" or Annual Physical does not mean that additional problems that are addressed by the physician will be covered by my insurance at 100%. I understand if the physician has to address an additional problem or complaint my insurance will be billed separately and I will be responsible for any co-pay, deductible, co-insurance or bill I may receive related to that problem but not limited to office visit, lab work, imaging and testing.

**Pay Insurance Benefits:** The undersigned assigns payment directly to MEA for all insurance and similar benefits otherwise payable to the Patient by virtue of medical treatment provided by MEA, but not to exceed MEA regular charges for medical treatment. The undersigned understands the Patient is financially responsible for charges not covered by insurance, and the undersigned agrees that the Patient shall be responsible for all charges incurred, regardless of the status of medical insurance or similar benefits.

**Medical Education:** I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty in accordance with organizational policies.

**Photography and Other Recordings:** I consent to photographs, audio, and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in exam room.

**Authorization for Healthcare-Related Calls, Texts and E-mails:** I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and to e-mails using any e-mail address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

MEA Medical Clinics
PO Box 1998
Madison, MS 39130

**Specimens:** Further, I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention, or medical treatment.

**Devices:** I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

Patient Name: _____
Patient DOB: _____

**Blood:** Further, I understand that should any medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires the hospital and/or physician to report certain infectious diseases including sexually transmitted diseases to the state's Department of Health.

**Payment Terms:** The undersigned understands that payment is due in full on the date of treatment for all services provided and the undersigned agrees to pay all charges for the Patient. MEA does not issue refunds to patients with a credit balance of less than $5.00 and will not issue invoices for balances owed of less than $5.00. After 90 days, these balances will be written off by MEA and any credit balances of the patient will be retained by MEA. The undersigned understands and agrees to MEA policy regarding credit balances of less than $5.00.

**Prescription History:** The undersigned authorizes MEA Medical Clinics obtaining the Patient's prescription drug history from pharmacy networks for safer patient outcomes.

**Release of Medical Information:** The undersigned authorizes MEA Medical Clinics and its physicians providing to the Patient's Insurance companies and· outpatient benefit programs the Patient's health information as needed to process insurance claims. The undersigned understands MEA participates in various health programs with insurance carriers and/or employers and may be required to submit the Patient's health information to the Patient's insurance carriers, employers, or outpatient benefit programs. The undersigned authorizes MEA providing the requested information related to the health program to the Patient's insurance carriers, employers, or outpatient benefit programs. The undersigned authorizes MEA Medical Clinics to use and disclose medical information and related healthcare date, as necessary, to administer and coordinate **Advanced Primary Care services (APC)**. This may include sharing information with employer or employer-sponsored health plan, claims administrators, third party administrators, and software platforms related to APC services.

**Release to Work or School:** If requested by the Patient's work or school, the undersigned authorizes MEA providing the Patient's work or school a written excuse.

**Consent for Retirement of X-Ray Film/Graphic Data:** The undersigned authorizes and consents to MEA retiring the Patient's x-ray films and any other graphic data, four (4) years after they are generated or created if the written and signed findings of a radiologist or other professional who has Interpreted the x-ray film or graphic data is maintained in the Patient's medical record.

***By signing below, I acknowledge that I have read this form, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have.***

**Patient Name (print):** _____

**Patient Signature:** _____

**Date:** _____ **Time:** _____

**Authorized Person for Consent Name (print):** _____

**Authorized Person for Consent Signature:** _____

**Date:** _____ **Time:** _____