Patient Name: _____

DOB: _____

Account #: _____

1. Consent for Treatment

- I consent to care by Lakeview Clinic providers and staff, including exams, tests, imaging, immunizations, prescriptions, and other necessary procedures. I understand I may refuse any treatment.
- Students in supervised training programs may assist in my care. I may decline their involvement without affecting my treatment.
- If a healthcare worker is exposed to my blood or bodily fluids during care, I consent to testing for infectious diseases to protect the worker.
- I consent to treatment via telehealth (video visits), understanding that technology issues may affect care and that emergencies require calling 911.

2. Code of Conduct

- Lakeview Clinic values respectful interactions. Threats, offensive language or behavior, sexual or vulgar actions, or disruptions to patient care will not be tolerated and may result in discharge from the clinic.

3. Authorization for Payment & Assignment of Benefits

- I authorize insurance or other benefits to be paid directly to Lakeview Clinic for services provided at Lakeview or by Lakeview providers caring for me at other clinics/facilities.
- I understand Lakeview contracts with third-party providers and laboratories for some tests and imaging. These providers may bill me directly. I consent to Lakeview sharing my insurance and demographic information with them as needed.
- I agree to pay charges not covered by insurance or other payors, and understand I am responsible for disputed claims.

4. Release & Use of Health Information

- I permit Lakeview Clinic and its agents (including Business Associates) to share and access my health information for treatment, payment, and healthcare operations, including:
  - Sharing information with other healthcare professionals, facilities, and anyone involved in my care, case management, or discharge planning.
  - Accessing my prescription history through pharmacy databases and state programs as required by law.
  - Sharing information with health plans, payers, and others as needed for eligibility, billing, claims, and payment.
  - Sharing information with accrediting and quality organizations, regulatory and public health agencies, and for quality improvement, fraud investigation, immunization tracking, and recalls.
- My information may be shared with health information exchanges and prescription monitoring programs as permitted by law.
- I permit my health plan to share information with Lakeview Clinic for treatment and care management.

5. Notice of Privacy Practices & Health Information Exchange

- I can find a copy of Lakeview Clinic's privacy practices at the front desk, posted in the registration area, and at www.lakeviewclinic.com. I can ask for a copy at any time.
- I understand this consent ends one year from the date of signature, except for payment purposes and sharing with Health Information Exchanges that require expressed revocation. I can ask for a copy of this form at any time.
  - Check here ☐ If you would like to exclude the sharing of your Lakeview Clinic Information in the Health Information Exchange (HIE) (electronic sharing of records with other clinics involved in your care)
- I may revoke this consent in writing at any time. No further release will occur after the date notified.
- I understand that other parties may disclose health information received from Lakeview Clinic.

6. Reminders and Care Messages

- I agree that Lakeview Clinic, its affiliates, and agents may use an automated telephone dialing system to make phone calls or send text messages to my home phone and cellphone number(s) I provided for treatment, appointment reminders, payment, health care operations, and other notification purposes. I understand that message and data rates may apply, that I may opt out of future notifications at any time, and that delivery of information and content to a mobile device may fail for various reasons. Accordingly, neither Lakeview Clinic nor the telecom carriers are liable for any delays or failures in the receipt of any text messages.

7. Signatures

By signing, I indicate that I understand and accept the terms on this form. Signature:_____ Printed Name:_____ Date:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian or Conservator ☐ Health Care Agent (Power of Attorney) ☐ Other Legal Representative _____	If the patient is 18 or older, the patient must sign and date the form. If the patient is 18 or older and unable to sign, a legally authorized person must sign and state their authority (with documentation if not already on file). If the patient is 17 or younger, the parent or legal guardian must sign unless an exception applies under the law.