BLUEBONNET DERMATOLOGY

GENERAL CONSENT/AGREEMENT TO OUTPATIENT SERVICES

This form must be signed by all new patients.

1. **CONSENT TO TREATMENT:** I consent to receive medical and/or cosmetic health care services provided by Bluebonnet Dermatology PLLC ("Bluebonnet"). I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **CONSENT TO PHOTOGRAPH:** I understand photographs, digital and/or other images may be made/recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

3. **ELECTRONIC PRESCRIBING:** I authorize SureScripts, an electronic prescribing network, to release my medication refill history to Bluebonnet for the purpose of continued treatment.

4. **MY PERSONAL BELONGINGS:** I understand that I am responsible for my personal belongings and valuables.

5. **RELEASE OF INFORMATION:** I authorize Bluebonnet to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

   If I am covered by Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this

facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

6. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that when I provide my landline or cell phone number(s), I am giving express consent for Bluebonnet and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of Bluebonnet. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   I may be contacted via voicemail, text, or email to remind me of an appointment, to obtain feedback on my experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications, unless I request a change in writing by completing the below revocation form.

I agree to the terms as outlined in the Agreement.

Name (Print): _____

Signature: _____

Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____