1. GENERAL CONSENT TO MEDICAL TREATMENT

I hereby request and consent Franciscan Physician Network (this practice) and their employees and agents ("Provider") to attend me during my treatment and perform routine tests and procedures and to provide certain health care services as prescribed for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by Provider, nor have I relied upon any such representations, warranties, or guarantees. I understand that physicians who hold limited licenses to practice medicine and are currently in residency programs and/or other health career students may assist with my care and treatment, within the scope and limitation of the applicable health education program, during my office visit. Resident physicians and other students of health care will be supervised by instructors or office staff.

2. CONSENT TO PHOTOGRAPH

I hereby consent to present a photo identification to confirm my identity as a patient who will receive treatment from Provider.

Photographs may be taken with a Franciscan Physician Network owned camera for assessment and treatment of medical conditions. I understand that the photographic image will be stored in my confidential medical record.

Initial here if you are declining to have your photograph taken for treatment purposes: _______

3. MyChart ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT

If available, I hereby request access to MyChart and understand that in order to gain access to MyChart I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of MyChart is subject to certain terms and conditions. I agree to review MyChart terms and conditions before accessing MyChart and further agree that by accessing MyChart I am agreeing to abide by the MyChart terms and conditions. To gain proxy access for children 12-18, a separate MyChart proxy access form will be used.

MyChart IS NOT available for this practice site (FPN staff to indicate): _______
MyChart IS available at this practice site (FPN staff to indicate): _______

Initial here if you are declining electronic access to your medical record: _______
Initial here if you consented previously to MyChart and wish to continue using MyChart: _______
Initial here if you are declining MyChart use for children between the ages of 12 and 18: _______

4. FINANCIAL AGREEMENT

I hereby agree to pay Provider their charges for all services rendered during my treatment. I shall also be responsible for any attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to Provider payment to any health insurance benefits, including but not limited to any and all applicable Medicare and Medigap benefits, applicable to this treatment and authorize the release of information necessary to determine coverage and to permit reimbursement on my behalf to Provider. Such payments, however, shall not exceed my balance owed to Provider. I hereby certify that any information which I have given in applying for coverage under Title XVII and/or Title XIX of the Social Security Act, or any insurance or other information which I provided is true and correct.

5. TELEPHONE/CELL PHONE NUMBER

In order to contact me related to my healthcare and financial arrangements, I authorize Franciscan Alliance, Inc. and its designees to utilize any and all of my contact information (including my email and cell phone) provided to Franciscan Alliance, Inc., or any of its divisions, and utilizing various methods including automated calling, texting and the use of pre-recorded messages.

6. REVOCATION OF CONSENT

I may revoke this consent at any time except to the extent that any Franciscan Physician Network practice has already taken action in reliance on it.

7. INDIANA LAW AND JURISDICTION

I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

For any line item of this consent I have initialed in the designated area indicating a declination, I understand that indicates I do not agree with that section and do not consent to the options described in that section.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by Franciscan Physician Network.

______________________________ ________________ ___/___/______
Patient Printed Name | Date | Patient Date of Birth

______________________________ ________________
Patient Signature | Date

______________________________ ________________
Patient's Legal Guardian or Responsible Party Signature (if applicable) | Date

______________________________ ________________
Witness | Date

Patient last 4 of Social Security Number: ___________________

REV 03/2015