CONSENT FORM

PATIENT NAME:_____

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) am suffering from a condition requiring treatment, I voluntarily consent to such care. I consent to routine diagnostic procedures, x-rays, and to medical treatment by physicians in AtlantiCare Physician Group and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Physician Group. Patients at AtlantiCare Physician Group will be treated regardless of race, color, age, national origin, disability or religion.

Signature of patient or patient representative: _____ Date from:_____ to: 12/31/2021

(Representative signature required if patient is minor or unable to consent): _____

Representative's relationship to patient: _____ Witness: _____

Patient is unable to consent because: _____

Acknowledgement of Privacy Practice: I understand and have been provided with AtlantiCare's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

Signature of patient or patient representative: _____ Date from:_____ to: 12/31/2021

General Terms and Conditions:

1. I understand that as a part of my healthcare, AtlantiCare Physician Group originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. This information is used as described in the Notice of Privacy Practices and to: plan my care and treatment, communicate with professionals involved in my care, apply my diagnostic and procedural information to my bill, verify third party payers the services provided, and routine operations such as audits reporting requirements, utilization review, and quality assessment activities.
2. I am aware and have been advised that I (or the patient) am suffering from a condition requiring treatment and I am presenting myself for treatment and I voluntarily consent to such care. I consent to diagnostic procedures and medical treatment by physicians at AtlantiCare Physician Group's medical staff and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Physician Group.
3. AtlantiCare Physician Group maintains patient medical records in paper, microfilm and /or electronic media, including photo identification, which may be accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Medical records are disclosed according to applicable New Jersey State Laws, Federal laws 42 & 45 C.F.R. and the provisions of this consent.
4. I hereby assign to AtlantiCare Physician Group physicians participating in my care and other licensed providers any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold AtlantiCare Physician Group harmless for any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, pre-certification, prior or retrospective authorization, or utilization review of the medical services I receive. I agree that I am financially responsible for deductibles, coinsurance and uncovered services that are not covered by my insurance policy.
5. I agree to pay AtlantiCare Physician Group the full and final amount of any and all bills rendered for me (or the named patient) which are not covered by insurance. I authorize AtlantiCare Physician Group to utilize the appeals process with my insurance carrier in my behalf for any denied service.
6. I certify that the information given by me in applying for payment under titles XVIII and XVIX of the Social Security Act is correct. As acceptable, I certify that I have received the Important Message from Medicare.
7. I consent to access by AtlantiCare Physician Group of my prescription history from external pharmacies in order to electronically verify my medications as needed to improve the accuracy of my medication list.
8. Communication: By providing my telephone number, I consent to health care related communicates (e.g., appointment reminders), patient satisfaction surveys and similar purposes, as well as to receive contact from APG or its designee on my financial responsibility in various methods such as but not limited to text message, email, or pre-recorded voice message.

By signing this consent, I am indicating that I understand the contents of this document and agree to its provisions including the disclosure of information in accordance with AtlantiCare's Notice of Privacy Practices. I am signing this consent voluntarily.

Signature of patient or patient representative: _____ Date from: _____ To: 12/31/2021

Representative's relationship to patient _____ Witness: _____

Patient is unable to consent because: _____

AtlantiCare PRIMARY CARE PLUS | FAMILY MEDICINE CENTER

Please Read!

APG FMC Refill Policy

Prescription refills should be requested during your office visit!

Physicians ask that you bring your medication bottles with you in a bag to all routine, physical and wellness visits. This will help ensure accuracy of medication reconciliation.

Please give **ONE WEEKS NOTICE for ALL prescription refill requests outside of an office visit,** allowing 7 days for medication to be refilled.

We recommend you call to request refills on the day your doctor is in the office.

The Physician On-Call does not do prescription refills.