Mary Louder, DO/Cairn Medical Group
2595 Canyon Blvd, STE 220, Boulder, CO 80302
PH 303-722-9000 Fax 1-844-800-1478

Patient Consent Form

Name: _____ Date: _____ DOB: _____

To our patients: Before you begin treatment at the Cairn Medical Group, the law requires we explain your rights and responsibilities. If you have a complaint or concern about your care, please talk to Dr. Louder. Phone is 303-722-9000.

Please initial below:

_____ **CONSENT FOR TREATMENT:** By signing this form, I consent to and authorize my health care provider to treat me. I understand this could include lab tests, x-rays, education, supplements, medications or other diagnostic/therapeutic procedures. I understand my provider is available to explain my treatment, and that I have the right to refuse treatment.

_____ **RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:** I understand it is important that **medical providers** have access to my medical records to help them safely treat me and manage my medical care. I agree and understand that a copy of my medical records, including AIDS, HIV, behavioral health service, psychiatric care and treatment for alcohol or drug use, will be included as part of my health and medical records. (Unless I decline) I also agree that Cairn Medical Group can release my medical records to **accrediting or regulatory agencies** if those agencies request my records, and if the law allows those agencies to see my records.

_____ I agree to pay Cairn Medical Group for all charges at time of service including co-pays and deductibles. I agree that if there are procedures or products/supplements not covered by insurance, these charges will be fully disclosed prior to the procedure and there may be a separate informed consent and fee schedule for those individual procedures. These fees will be disclosed. I agree to pay for all non-covered procedures, treatments and services at the time of care (day of appointment) unless otherwise agreed upon.

_____ I understand that I am fully responsible for my deductible and for knowing and understanding my individual insurance policy and coverage details. I understand that I am responsible for communicating with my insurance company regarding issues of my deductible, co-payments, and rejections. Cairn Medical Group will assist me with this to the best of their ability, but I am ultimately responsible for my payments and fees due for medical care and services.

_____ **RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:** Most of the time, a "third party payer" will pay part or all of my medical bills related to today's visit. Examples of "third party payers" are medical and auto insurance companies, workers' compensation insurance carriers, Medicare, United Health Care etc. I understand and authorize Cairn Medical Group to release any information about the medical treatment I receive in order for a third-party payer to pay for any or all of my bills related to today's visit.

_____ **RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:** Medical records may be reviewed to answer questions about how your care was delivered, the quality of care received or to identify your eligibility for a medical research study. Initialing this box means that your records can be reviewed by select individuals at Cairn Medical Group for help in these kinds of studies. It also means your provider may contact you about your interest in a study. No personally identifiable information will be shared with outside parties without your written consent. Checking this box does not affect your treatment in any way.

_____ **PATIENT RIGHT PRIVACY:** I acknowledge I have been told about Cairn Medical Group's privacy practices and HIPPA regulations, which are provided through the office. I have been offered a copy of Cairn Medical Group's notice of privacy practices to keep for myself (if requested)..

AUTHORIZATION TO COMMUNICATE THROUGH AN ANSWERING MACHINE, EMAIL:

_____ I authorize Cairn Medical Group to leave messages about my private health information on my home or cell answering machine or voicemail, with an individual who answers my home phone/cell phone or email. I further authorize Cairn Medical Group to send lab results via unencrypted email that cannot be sent through the Practice Fusion EHR portal. I understand that to be fully HIPPA compliant the emails need to be sent through the PRACTICE FUSION EHR portal only. Any email through another site such as Google, Yahoo, Comcast (etc.) is NOT HIPPA COMPLIANT, ALTHOUGH IT MAY BE SECURE. I further understand to not hold liable Dr. Louder or the Cairn Medical Group for voicemails, emails or for social media postings that I initiate as a patient. Dr. Louder's preferred method of electronic communication is the PRACTICE FUSHION EHR patient portal.

_____ **SOCIAL MEDIA:** I understand that if I post any of my private health information on any social media site or page, I am solely responsible. I will not hold liable Dr. Louder or the Cairn Medical Group for actions that I initiate. I understand that Dr. Louder and the Cairn Medical Group will not be posting any HIPPA or private health information on any social media site at any time. From time to time, there may be a story or blog that the context seems familiar, but this in no way implies that it is my personal health information being shared through social media. I understand that many patients may present with similar symptoms, conditions and may receive similar treatments through Dr. Louder and Cairn Medical Group.

_____ **CONSENT FOR MEDICAL PHOTOGRAPHY:** I understand and consent for medical photographs to be made of myself or my child or family member that I am signing for. I understand that the information may be used in my medical record, for purposes of identification, medical teaching, or for publication in medical textbooks or journals as I have designated below. Although these photographs may be used, they will be without identifying information such as my name; I understand that it is possible that someone may recognize me. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

_____ **SCHEDULING FEES:** If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge for any appointment, which is not canceled with proper notice. You cannot text to cancel an appointment. You may email though the secure PRACTICE FUSION EHR portal or by phone or through established email channels agreed upon.

_____ **UNPAID ACCOUNT BALANCES:** In the event that you fail to make payments for services rendered, your account may be turned over to a collection agency. You will be responsible to pay the collection agency's fees that may be incurred in the collection of any outstanding balance or debt.

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Patient Signature **Date**

If other person, relationship to patient: _____

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Signature **Date**