Legal Consent Form (OHP)

____________________ ______ ________________ _____/_____/________
Patient First Name MI Last Name Date of Birth

Initial each section and sign below

____Consent to Medical Care and Treatment: I consent to all medical and surgical care, examination, and tests determined to be necessary. I understand that I have the right to refuse any procedure or treatment and I have the right to discuss all medical treatments with my clinician. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse suggested examinations, tests, or treatments against medical advice, I will not hold Pacific Sage LLC or any individual responsible for any of the consequences.

____Assignment of Benefits, Authorization to Release Medical Information: I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Pacific Sage LLC for any services furnished to me by Pacific Sage LLC and hereby assign Pacific Sage LLC all assignable rights to payment for services rendered by Pacific Sage LLC including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to Pacific Sage LLC. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related cservices: Centers for Medicare and Medicaide Services, insurers, and/or agents of these companies, or other helathcare providers assisting in my medical care. I understand and agree that my health inormation may be used and disclosed by Pacific Sage LLC, other providers, and insurers for treatment, payment, and health care operations pursposes. I understand that Pacific Sage LLC paricipates in an electronic medical prescribing softward (e-prescribing) and authorize Pacific Sage LLC to send prescriptions directly to a pharmacy from the point of care. I agree that Pacific Sage LLC may request and use my prescription history from other healthcare providrs or third-party payors for treatment pursposes.

____Financial Agreement: I understand that Oregon Health Plan will pay for the costs of my visit but I may be required to pay a copay. There may be additional charges from other entities that provide services ordered by Pacific Sage LLC, but those entities will bill and collect payment(s) independently.

____Consent to Text Messaging and email: In order to enhance patient care and experience, Pacific Sage LLC may contact me via phone call, voicemail, SMS text message, email, or mobile application, some of which may be via automated means to remind me of an appointment, to obtain feedback on my experience with our healthcare team, and to provide general health reminders/information. I understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, I may opt-out of receiving text messages by notifying Pacific Sage LLC in writing. Standard telephone minute and text charges may apply if Pacific Sage LLC contacts me.

____Acknowledgement of Notice of Privacy Practices and Patient Record of Disclosures: I acknowledge that I have received a copy of Pacific Sage LLC's Notice of Privacy Practices. In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI is made by alernative means, such as sending correspondence to the indivicual's office instead of the individual's home.

____Video Surveillance for Security and healthcare Operations: I understand and consent to video surveillance for security purposes and/or Pacific Sage LLC's health care operations. I understand that the facility retains the ownership rights to images and/or recordings. I understand these images and/or recordings will be securely stored and protected.

____By signing below, I hereby understand and agree with the above information and understand that my refusal to sign this form will be interpreted as my decision to cease receiving medical care with Pacific Sage LLC, which also goes by the names of Pacific Sage Primary Care and Pacific Sage Medical Services.

______________________________	____________________
Patient's Signature	Date
___________________________________	____________________
Authorized Representative Signature	Date
___________________________________	____________________
Name of Representative	Relationship