Agilance
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General Registration Acknowledgement and Consent Form

Financial Policy: Assignment of Insurance Benefits and Consent to Pay

Although you may have health insurance, your insurance policy may not cover all or part of the healthcare services you receive from our practice. It is your responsibility to understand the terms of your health insurance coverage, including coverage for preventive care, non-preventive care, laboratory services, imaging external specialist care and services provided electronically (telehealth services). It is also your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

Please read and consent to the following:

a) I hereby consent to assign directly to Agilance all payments for healthcare services they provide to me or my child and to which I, or my child, may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my or my child's medical care. I understand that I am financially responsible for all charges, whether or not paid by the any of the above agencies. I hereby authorize the doctor to release all information necessary to substantiate the payment for such medical care or medical service and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I further agree that a photocopy of this agreement shall be as valid as the original.

b) I also understand, that should I or my child undergo any tests (such as laboratory, imaging, consultation or other) or any other services provided by other facilities or services provider(s) during the course of my evaluation or treatment, whether ordered by providers of Agilance or other medical professionals, I will be responsible for payment of the balance (whether directly or through my insurance) to any such rendering facility or service provider(s) and I will not hold Agilance, or any of its providers, liable for the costs of such tests.

c) I certify that the information I provide about myself and my child such as the address, contact, insurance and other information pertinent to my care or the care of my child is valid, true and correct.

Confidentiality: Notice of Privacy Practices

The Notice of Privacy Practices explains how medical information about you or your child may be used and disclosed, your rights concerning this information, and instructions on how you can access this information. The Notice is attached with the registration form and also can be viewed at our website (www.agilance.com) on the footer. Please review the Notice.

I acknowledge that I have received, read, and have had the opportunity to ask questions about the Notice of Privacy Practices.

Communications: Consent to Use Electronic Communication

The majority of our patients request communication and notification about various care-related matters via electronic media, especially email. We are pleased to offer our patients the opportunity to communicate with us about their healthcare in this way. This consent relates to the following health information:

- Appointment reminders
- Reminders for referral appointments
- Laboratory results
- Diagnoses
- Billing or other care-related matters
- General health and/or illness information

I would like to receive the health information listed above via unencrypted email at the following address _____, which I may update with the practice from time to time. I understand that unencrypted correspondence, including email, is vulnerable to being intercepted, read, diverted or otherwise accessed by known or unknown parties, and that Agilance cannot guarantee the security of unencrypted email correspondence. By signing below, I indicate my understanding of these risks and agree to receive my medical records and health information by way of unencrypted email.

Telehealth Services

Agilance are pleased to offer our patients electronic access to our healthcare services, including telephone and email consultations and virtual "telehealth" office visits via simultaneous audio and video transmissions through services such as Skype or FaceTime. These services, which we are calling collectively our "telehealth" services, are actual medical services and, as such, our team is committed to providing the same high quality healthcare as we do when our patients visit our offices in person.

If you request telehealth services for you or your child, you will be asked separately to consent to receiving care using telehealth services and to authorize the sharing of electronic information between your electronic devices and our practice.

Free Choice of Care Policy

I, as a patient, parent or guardian of a child understand that I or my child is free to choose any treatment, test or physician, and I or my child may change our preferences at any time. I also understand that I or my child have the right and responsibility to ask questions if there is any information about which I am unsure or wish to have clarified, or if I wish to change any part of my medical care. I also understand that I can contact this office and voice my concerns should I have any questions. I furthermore understand that if I provide any misleading information, engage in an inappropriate behavior, fail to comply with recommended treatment or continually miss any appointments, the office reserves the right to terminate my patient physician relationship.

I hereby declare that I have read, understand, and have had the opportunity to ask questions about the information outlined above and, on behalf of myself or my child, consent to the terms and policies summarized in this document.

_____ _____

Signature of Parent or Legal Representative **Name:** _____ Date