THE BHALANI UROLOGY INSTITUTE

CONSENT TO PRACTICE POLICIES

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at THIS MEDICAL PRACTICE. This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals The Minor Procedures are performed by a physician or qualified midlevel provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to each Practice or any lab used by the Practice retaining any tissue specimens, medical devices or foreign objects removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Downloaded Prescription Records. Each Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will notify the Practice in writing. I understand that my written revocation of consent will not be effective until received and acknowledged by the Practice in writing and it will not have any effect on actions taken prior to such revocation. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. (3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time. If I have questions about any laboratory testing, I will ask my physician about the purpose of the test and may refuse it at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will notify my physician or other care provider at the time of service.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Privacy, Individuals Involved In My Care. I understand that, unless I request confidentiality, the privacy laws allow the Practice to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with me.

Telehealth. I consent to telehealth consultations recommended by my physician. During the consultation, my medical history and test results may be discussed with Georgia licensed health professionals through telecommunication technology. In some cases, a physical exam will be performed. Unless I object, a nonmedical technician may be present to assist with the technology and, audio or video recordings may be taken. I can withhold or withdraw consent to the telehealth consultation at any time without affecting my right to future care, or risking the loss of any benefits to which I may be entitled. I have been informed of available alternative options which may include in-person services. All state and federal laws, including privacy and confidentiality, apply to records of the telehealth consultation. The consulting physician will inform me of any other risks or benefits of the telehealth consultation. I have the right to see appropriately trained staff in-person immediately after the telehealth consultation if an urgent need arises. By scheduling or participating in telehealth services, I am consenting to those services.

PHOTOGRAPHY AND RECORDING. Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

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BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice; The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;

I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and

If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____ _____

Witness Date/Time Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient If Not the Patient

_____ _____

Interpreter Signature Date/Time Reason Patient Unable to Sign

Note: If phone/video interpretation used, record interpreter ID# Interpreter comments (optional): _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from The Bhalani Urology Institute. The Notice provides information about how may use and disclose my health information. I have been encouraged to read the Notice in full.
I understand that operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date/Time Relationship to Patient If Not the Patient

_____

Interpreter Signature Date/Time

Note: If phone/video interpretation used, record interpreter ID# Interpreter comments (optional):_____

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other:** _____

NOTICE OF NON-DISCRIMINATION

The Bhalani Urology Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you.
The Bhalani Urology Institute cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

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Patient Authorization to Release Medical Information

_____ _____ ____/____/ ____

Patient Name (please print) SS or Health Record Number Patient DOB

_____ I authorize (doctor/doctor's office) to use or release/disclose my health information as described below.

Name of Practice/Physician: _____ Fax: _____

Please identify the information to be released:

☐ Please release my entire record

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other healthcare providers as needed
☐ Other (please describe): _____

I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and /or treatment for alcohol and drug abuse.

I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure healthcare treatment. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: The Bhalani Urology Institute **Email: bhalaniurology@gmail.com**

Address: 960 Sanders Road, Suite 500, Cumming GA 30041 **Fax: (678)-968-4784**

This authorization will expire on (insert date or event):_____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ____/____/ _____

Patient Signature (or Signature of Person Completing From if Not Patient*) Date

*Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ ____/____/ _____

Witness Signature Date