

DIGNITY EXTENSIVISTS OF CENTRAL TEXAS

Consent for Medical Evaluation, Facility Rounding, and Treatment

PATIENT DEMOGRAPHICS

Patient Name _____ DOB _____

Address _____

Phone _____ Facility / Residential Setting Name _____

1 AUTHORIZATION FOR CLINICAL CARE & FACILITY ROUNDING

I hereby grant consent to Dignity Extensivists of Central Texas, its physicians, nurse practitioners, physician assistants, and allied healthcare professionals ("Provider Group") to conduct medical evaluations, perform diagnostic tests, administer medications, perform routine bedside procedures, and deliver ongoing clinical care. This consent applies to facility rounding visits in participating skilled nursing facilities, assisted living centers, and post-hospital home visits across Central Texas.

2 ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

- a. **Assignment of Insurance Benefits:** I authorize payment of medical benefits directly to Dignity Extensivists of Central Texas for professional services rendered.
- b. **Financial Responsibility:** I understand that I am financially responsible for any applicable deductibles, copayments, coinsurance, or services determined to be non-covered by Medicare, Medicaid, or my private insurance provider under Texas billing laws.

3 TELEHEALTH & REMOTE CARE CONSENT

I consent to receive healthcare services via telehealth technology (including secure video and telephone consultations) and Remote Patient Monitoring (RPM) when deemed clinically appropriate by my attending practitioner.

4 NOTICE OF PRIVACY PRACTICES (HIPAA) & TEXAS HEALTH INFORMATION EXCHANGE

- a. **Privacy Acknowledgment:** I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices outlining how my Protected Health Information (PHI) is used and protected under federal HIPAA standards and the Texas Medical Records Privacy Act.
- b. **Health Information Exchange (HIE):** I authorize Provider Group to access and share necessary medical data with local health information exchanges (such as HASA or local Texas HIE networks) for care coordination purposes.

5 REVOCATION & DURATION

This consent shall remain valid for one (1) year from the date of signature below unless revoked by me in writing. Revocation will not affect actions taken prior to receipt of written notice.

SIGNATURE & ACKNOWLEDGMENT

Patient Signature _____ Date _____

If signed by Legal Representative

Legal Representative Name _____

Relationship / Authority (e.g., MPOA, Guardian) _____

Representative Signature _____ Date _____