JAIME ALTAMIRANO, M.D., P.A

Consent and Acknowledgement Form

Consent to Treatment
I consent to all medical and cardiac procedures and treatment, including but not limited to cardiac procedures, medical treatment, radiological examination, anesthesia, laboratory procedures, and medication that may be performed, administered or rendered by or under specific or general instructions of my physician. I hereby voluntarily consent to rendering of medical treatment by Jaime Altamirano, M.D., P.A. and/or the medical staff, which may include routine diagnostic and/or surgical procedures, x-rays and administration of injections, therapy and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

Open Door Policy
Due to the nature of the practice, Jaime Altamirano, M.D., P.A. has an open door policy. Treatment areas are kept open and examining room doors may be kept open. If you have any questions or objections to this policy please inform the physician or the designated health care provider.

Appointment Reminders
I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. I authorize the use or disclosure of medical information to contact you as a reminder. This contact may be done by phone, email, or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and/or objections to this policy please inform us.

Consent to Photograph
I authorize Jaime Altamirano, M.D., P.A. to take pictures of my medical or cardiac procedure(s) and condition(s) and to the use of such pictures for treatment, scientific, educational or research purposes.

Personal Valuables
I acknowledge that this practice/facility does not accept responsibility for any personal property. I accept the risk of loss or damage to any of my personal property.

Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations
I understand that as part of my health care, Jaime A. Altamirano, M.D., P.A originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:
A basis for planning my care and treatment.
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing the consent
The right subject to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information maybe use or disclose to carry out treatment, payment, or health care operations.

I understand that Jaime Altamirano, M.D., P.A. is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing. I also understand by refusing to sign this consent or revoking this consent Jaime Altamirano, M.D., P.A. may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Jaime Altamirano, M.D., P.A. reserves the right to change their notice and practices in accordance with section 164.520 of the Code of Federal Regulations. Should Jaime Altamirano, M.D., P.A. change its notice, I have the right to obtain a copy of any revised notice.

I understand that as part of this organization's treatment, payment or healthcare operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I acknowledge that I have read and reviewed the ***Notice of Privacy Practices*** and I am in agreement of such.

I acknowledge that this form has been fully explained to me and that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to those provisions individually and collectively.

Patient Signature: _____ **Date:**_____