All Patients General Consent

Palmetto Health **USC**
MEDICAL GROUP

Patient's Name _____ DOB_____ MRN_____

1. I consent to this entity performing as applicable: blood draws, medications, tissue disposal/donation, examinations, treatments, lab tests, therapy, transportation, evaluation and treatment services, procedures, and anesthetics as may be necessary in accordance with the judgment of the authorized physicians and/or clinicians, including appropriately supervised students, residents, and telehealth providers. Treatment may be provided by authorized employees of Palmetto Health, the University of South Carolina or the Palmetto Health-USC Medical Group. I acknowledge that no guarantee can be made concerning the results of treatments.
2. I acknowledge receipt of Notice of Privacy Practices, which may be found at **www.phuscmg.org**.
3. I would like to receive email invitations to the online patient portals.
4. I acknowledge that my photograph may be taken for identification purposes, that cameras and video cameras may be used for observation and medical documentation purposes, and that the images are the property of this entity unless I withdraw my consent in writing.
5. I give permission to share my electronic medical record among my health providers and obtain medication history through a Provider Health Information Exchange (HIE) which will follow state and federal laws regarding access by medical providers of any protected information. I may opt out of the HIE and continue to receive care.
6. I consent to the use of the electronic prescription system, which allows prescription history and related information to be electronically shared between my providers and my pharmacies.
7. For the protection of myself and others, I give permission to have blood drawn and tested for infectious diseases including, but not limited to, HIV (AIDS virus) and Hepatitis.
8. I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and department of health and environmental control and that this entity participates in the South Carolina Dept. of Health's statewide immunization registry, which complies with federal health information privacy laws.
9. I give permission to send or fax childhood immunization records to schools or my employer, upon request.
10. I acknowledge receipt of the Patient Financial Billing Policy. In the event that I fail to make payment or comply with payment arrangements, collection measures may be initiated and my credit report can be obtained.
11. By listing a phone number, I give permission to leave messages on my answering machine/voicemail.

    Phone_____

    By listing an email or mobile number, I give permission for appointment reminders to be emailed and/or texted to me

    at_____

    By listing a phone number, I give permission to leave messages on my voicemail at my place of employment.

    Phone_____
12. I have an Advance Directive (Living Will or Healthcare Power of Attorney) (Circle one) YES or NO

    I have been offered information or assistance regarding Advance Directive (Circle one) YES or NO or N/A
13. I understand that this entity is not responsible for the loss or damage of any valuables. Any valuables not claimed within 30 days of my visit become the property of this entity to include electronic devices.

I FULLY UNDERSTAND AND AGREE TO THE CONDITIONS CONTAINED IN THIS FORM.

_____ _____
Signature of Patient or Legally Qualified Representative | Date/Time

_____ _____
Printed Name of Patient or Legally Qualified Representative | Relationship to Patient

_____ _____
Palmetto Health-USC Medical Group Representative | Date/Time