Lexington Health

2720 Sunset Boulevard, West Columbia, SC 29169 • **LexHealth.com**

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize and grant permission to the physicians, nurse practitioners, physician assistants, midwives and their assistants, and other health care professionals of Lexington Health physician practices to:

- Provide reasonable and necessary medical care, diagnostic evaluation and treatment considered advisable by my providers.
- Contact me on any phone number provided by me for the purposes of conducting business with me or contacting me concerning my account and use automated dialers for that purpose. Phone calls to and from Lexington Health's physician network may be monitored and recorded.
- Examine, use, store and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body.
- Conduct limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C, and HIV, in the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance capable of transmitting disease and I am unable to consult timely with my physician prior to testing.
- Use advanced artificial intelligence (AI) technologies to enhance patient care. AI applications include, but are not limited to, transcription of medical notes, support in clinical decision making, personalized treatment planning, predictive health analytics and targeted outreach campaigns. AI data is stored in compliance with HIPAA regulations. AI tools do not make clinical decisions or replace the expertise of your provider. I understand that my providers will review and finalize AI-generated documentation. If I have questions related to the use of AI in my care, I understand that I should ask my providers.

SPECIAL PERMISSIONS

I authorize and grant permission to Lexington Health physician practices to perform the following tasks and express my objection to specific tasks by crossing through and initialing next to them:

- Take and use photographs of me in connection with my medical care and treatment. These photographs will not be used for marketing purposes without my express written consent.
- Participate in AI ambient listening. If I wish to limit or decline AI ambient listening usage, I understand that it is my responsibility to discuss it with my providers. My care and treatment will not be affected if I choose to limit or decline AI ambient listening usage.
- Permit students/residents, under the direct supervision of my physicians, to observe and participate in my care and treatment. I will be given the opportunity to withdraw consent at any time prior to or during an appointment.
- Communicate with me by the cell phone number provided by me, to include text and/or voice, about my health care as well as all business notices, which includes, but is not limited to, accounting notifications, billing information and collection messages. I authorize health care communication to include, but not be limited to, appointment reminders, appointment confirmation messages, postoperative or home health care instructions, post-discharge information, lab results and prescription notifications.

RELEASE AND ASSIGNMENT OF BENEFITS

I authorize and grant permission to Lexington Health physician practices to release any medical information to (1) an insurance company through which I claim benefit and (2) any health care provider involved in my medical care. I authorize and direct my insurers to pay directly to Lexington Health physician practices and/or its physicians any and all benefit up to the amount of my bill pertaining to all charges incurred. I assign to Lexington Health physician practices, including its affiliates, any and all benefit or proceeds, of any type whatsoever, to which I am entitled with respect to the care and treatment I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefit due from any third party insurance policy. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over to a third party for collection.

Print Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Responsible Party Signature (if different):_____ Date:_____