



Patient Consent & Acknowledgment

Patient Name _____ Date of Birth _____

Assignment of Benefits

I hereby authorize IM Clinic LLC to apply for benefits on my behalf for covered services rendered by the office or by the office's order. I request that payment from my insurance company be made directly to IM Clinic LLC, or to the party who accepts assignment. I certify that the information I have reported about my insurance coverage is correct.

Financial & Office Policies

I certify that I have read and agree to the IM Clinic Financial & Office Policies. I have been directed to the most up-to-date version of this document at imclinic.org/forms.

Notice of Privacy Practices

I acknowledge that I am aware of the IM Clinic LLC Notice of Privacy Practices (Form 8.0). I acknowledge that I have either been given a copy for my own reading and records or have been directed to this document at imclinic.org/forms.

Virtual and AI Scribes.

I understand that IM Clinic may use a remote virtual scribe and/or an AI-assisted scribe that may listen to, record, and transcribe my visit to help my provider document my care. My provider reviews and finalizes every note, and recordings are deleted once the note is complete. If I do not want a scribe or AI tool used at a visit, I must notify my provider verbally at that visit, in person or at the start of a telehealth visit.

HIPAA Privacy and Release of Information Authorization

I hereby authorize IM Clinic LLC and its business associates, employees, and agents to use and disclose protected health information (for example, information relating to the diagnosis, treatment, claims payment, and healthcare services provided or to be provided to me, and which identifies my name, address, Social Security number, or Member ID number) for the purpose of helping me resolve claims and health benefit coverage issues. I understand that any protected health information released to the person or organization identified above may be subject to re-disclosure by such person or organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to IM Clinic LLC; however, this authorization may not be revoked if its employees or agents have taken action on it before receiving my written notice. I understand that I have a right to a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign it, and that my refusal will not affect my eligibility for benefits, enrollment, payment for, or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, and Assignment of Benefits policy, and I authorize the practice to obtain my medication history.

Communicating Your Health Information

If family members call requesting information about your healthcare, who may we release this information to?

☐ Yes, release to the people below ☐ No, do not release

Name	Relationship	Phone

Email and Text Message Communication

I consent to my physician and other IM Clinic staff communicating with me by email and/or standard text (SMS) message about my medical care, which may include, but is not limited to, test results, prescriptions, appointments, and billing. I understand that email and standard text messaging are not confidential methods of communication and may be insecure, and that there is a risk such messages could be intercepted and read by a third party. Message and data rates may apply.

Email: ☐ Yes ☐ No

Text message: ☐ Yes ☐ No

Voicemail on personal phone: ☐ Yes ☐ No

Voicemail at office/work number: ☐ Yes ☐ No

Patient Signature _____

Date _____

Representative (if any) _____

Relationship _____

These agreements will remain in effect as long as you are a patient at IM Clinic LLC, unless we are advised in writing of the need to make a change.