Dakota RADIOLOGY

Patient Last Name:______________________________

First Name: ______________________________

Date of Birth: ______________________________

Patient MRN#: ______________________________

Consent to Treatment

1. **Consent for Medical Care.** The Undersigned, whether as patient or as agent, consents to the following:
   a. All initiation of care, consultation, treatment, and procedures to be performed (including emergency treatment or services). The treatment and procedures may include, but are not limited to, laboratory tests, x-rays, physical examinations, injections, medical or surgical treatments or procedures, anesthesia, other services rendered under the general and special instructions of the patient's provider, or restraints that are necessary for safety and / or medical healing .
   b. Testing for HIV antibody (AIDS), hepatitis, or bloodborne pathogen should the healthcare worker have an exposure to the patient's blood or other body fluids.
   c. The disposal of any body parts or tissues removed according to Dakota Radiology policy, including the use of de-identified specimens for research purposes.
   d. Transfer and transportation to another facility for further care as instructed by the patient's provider.
   e. Allow the patient's prescription medication history to be obtained from external electronic sources.
2. **General Risks.** The Undersigned, whether as patient or as agent, understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. No guarantees can or have been made regarding the results of examination, procedures, or treatment.
3. **Release of Information.** The Undersigned, whether as patient or as agent, authorizes the following:
   a. Dakota Radiology may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable to pay for all or a portion of the charges. Dakota Radiology's authority shall include but is not limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits by telephone at the time of appointment check-in or during or after the appointment. The entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organizations, worker's compensation carriers, or government or other payors or their agents, such as utilization review, rehabilitation, or auditing agencies.
   b. Release of clinical information to providers and facilities for the purpose of continued healthcare. The patient or agent understands that healthcare providers participate in Monument Health's Connect Program, and that patient data will be stored in a shared community electronic record. This clinical data may be shared with Monument Health, its affiliates, and other healthcare providers whom are associated with the patient's medical care.
   c. That to support the care provided, Dakota Radiology is using technology in some settings that uses artificial intelligence to generate entries in the patient's medical record based on secure audio recordings, machine learning, and cloud-based voice recognition of the visit or exam. A third-party service processes the recording and creates information for the medical record that is reviewed and approved by the patient's provider.
   d. Gives consent to Dakota Radiology and its respective subsidiaries, affiliates, and vendors, to contact the Undersigned at the number provided using any means of communication, including, but not limited to, calls placed to a cellular phone using an automated dialing device and calls using prerecorded messages and / or SMS text messages, regarding any current or future accounts, outstanding balances, or payments owed to Dakota Radiology or its respective subsidiaries and affiliates even if the Undersigned will be charged by his or her service provider(s) for receiving such communications. The Undersigned understands he or she will be provided the option to update communication preferences during the servicing of accounts and will notify Dakota Radiology if he or she wishes to revoke this method of notification.
4. **Notice of Privacy Practices.** The Undersigned, whether as patient or as agent, acknowledges that the law requires that Dakota Radiology maintain the privacy of the patient's Protected Health Information and that Dakota Radiology provide a notice of legal duties and privacy policies with respect to protected health information. By signing below, the Undersigned acknowledges that he or she has received a copy of our Notice of Privacy Practices.

Patient, Parent, Guardian, Agent Name PRINT: ______________________________

Patient, Parent, Guardian, Agent Name: (Signature): ______________________________ Date:____________ Time:__________

If signature is other than patient's, print name and indicate relationship.______________________________

Witness (1) Name PRINT and SIGN:______________________________ Date:____________ Time: __________

Witness (2) Name PRINT and SIGN:______________________________ Date:____________ Time: __________
(If Applicable)