**I. Consent to Treatment**

I consent to the examinations, treatments and procedures that may be performed during my affiliation with Rest Assured Pulmonology Inc. If I am the representative/responsible party for another person or a minor, I also provide such authorization. This will include radiological examinations, laboratory procedures, medical and non-invasive treatments or procedures, or other medical or medically related services rendered to the patient under the general and special instructions of the physicians or allied health provider(s) of Rest Assured Pulmonology Inc. Additional informed consent may be required for certain procedures.

**II. Code of Conduct**

I have read and understand Rest Assured Pulmonology Inc’s Patient Code of Conduct.

Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within Rest Assured Pulmonology Inc premises. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non verbal remarks. No hostile communication or gestures regarding an individuals’ race, ethnicity, language or sexuality is permitted within Rest Assured Pulmonology Inc clinic. Appropriate attire and shoes must be worn at all times. Inappropriate exhibition, exposure and/or nudity will not be tolerated and violators will be removed from the premises.

**III. Lifetime Authorization – Medicare Certification for Payment**

I certify that the information given by me in applying for payment under Titles XVIII of the Social Security Act (i.e., Medicare) is accurate and correct. I authorize any holder of medical or other information about myself, or the patient I represent to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my or the represented patient’s behalf. I hereby assign the benefits payable for physician services to the physician or organization furnishing the services, and hereby authorize such physician or organization to submit a claim to Medicare for payment.

**IV. Assignment of Insurance or Third Party Benefits**

I authorize direct payment to Rest Assured Pulmonology Inc of any insurance, managed care, self-insured plan, or other third party benefits or state disability benefits otherwise payable to or on behalf of myself or the patient for services rendered, and assign to Rest Assured Pulmonology Inc, for application to patient’s account, all such benefits, payable at a rate not to exceed Rest Assured Pulmonology Incs regular rates and charges. I understand that I, or the patient I represent, will remain responsible for all charges or applicable co-payments not covered in whole or in part by the payor, subject to applicable law.

**V. Financial Responsibility Agreement**

By signing this agreement, whether as a patient, representative, or guarantor, I fully understand, acknowledge, and agree to each of the following: I will be fully financially responsible for any and all services rendered by Rest Assured Pulmonology Inc and its staff, whether covered or not covered by insurance, an employee benefit program, Medicare, Medicaid, or HMO. I agree to pay any additional account balances in full at the time of billing statement receipt.

Rest Assured Pulmonology Inc does not guarantee any “In-network” provider status. I understand that I am responsible for verifying the appropriate referrals and authorizations are in place as required by my insurance company. I understand Rest Assured Pulmonology Inc does not guarantee any coverage by insurance.

I agree to pay any additional account balances in full at the time of my next visit even if I have not yet received a billing statement.

I certify that I have read the foregoing, and I am the patient, guarantor, or the patient’s representative duly authorized to execute this Agreement and accept its terms.

**Consent to Receive Communications via E-mail, Telephone Calls, Text Messages,**

**Messaging and Postcards**

By signing below, I specifically request and expressly consent to receive from Rest Assured Pulmonology Inc and/ or its affiliated organizations, business associates and service providers (collectively & “Rest Assured Pulmonology Inc”) under the terms of this consent, messages and other communications (collectively, the “Communications”) to me through e-mails, telephone calls to my cell phone or landline (including voicemail messages on these lines), text messages, and/or postcards at the telephone number(s) and/or street address(es) that I have provided to Rest Assured Pulmonology Inc. I acknowledge and agree that the Communications may include but are not limited to: written or verbal messages reminding me of my appointments; information about my account balances or other billing or payment information; preventive care recommendations; instructions on how to electronically access my summary of care record following my evaluations; and reminders regarding Rest Assured Pulmonology Inc policies and procedures and patient

satisfaction surveys. I expressly acknowledge and agree that this consent includes communications that may contain Protected Health Information (“PHI”) as described in Rest Assured Pulmonology Inc’s Notice of Privacy Practices, including information about my diagnosis, medications, laboratory test results and other treatment related information. I agree that I am solely responsible and liable for the confidentiality and security of the street or email address(es) or telephone number(s) (cell and/or landline) that I provide to Rest Assured Pulmonology Inc, the security of the devices upon which I view or access the Communications, and the risks inherent in using electronic means to access the Communications, including risks that the Communications can be intercepted, altered, forwarded or used without authorization or detection.

I acknowledge and agree that I can designate a different email address or telephone number for the Communications by calling Rest Assured Pulmonology Inc, and I should do so if I believe that the address/telephone number that I provided to Rest Assured Pulmonology Inc is no longer secure or valid. I also acknowledge and agree that if I do not timely update my e-mail address/telephone number with Rest Assured Pulmonology Inc notification of important information and/or the possible disclosure of the communications to an unauthorized person. I acknowledge and agree that I may opt-out of receiving the Communications from Rest Assured Pulmonology Inc, through the channels described above by following the opt-out directions contained in the texts and/or verbal automated messages that I receive from Rest Assured Pulmonology Inc or by calling Rest Assured Pulmonology Inc at 727-500-5161.

I understand that Rest Assured Pulmonology Inc does not charge for providing me the communications, but I am responsible for any costs or expenses associated with the maintenance or operation of my e-mail or telephone accounts including, without limitation, text messaging fees that may be charged by my wireless carrier.

**Consent to Obtain External Pharmacy History**

Why are we asking for this?

An accurate prescription history reduces medication errors and enhances your safety. When you authorize Rest Assured Pulmonology Inc to access your external prescription history, you provide our staff with information about the medications you are already taking. This information will help Rest Assured Pulmonology Inc, your provider and/or staff to minimize adverse drug events. Drug interactions are examples of an adverse drug event. When you sign this consent, you agree that Rest Assured Pulmonology Inc may request and use your prescription medication history from other healthcare providers and/or thirdparty pharmacy benefit payers for treatment purposes.

**The Consent Statement**

I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by my provider and Rest Assured Pulmonology Inc staff. This may include prescriptions dating back several years. My signature certifies that I read and understood the scope of my consent and that I authorize access to my prescription history.

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Patient / Patient Representative’s Signature