CONSENT FOR PARTICIPATION IN A GROUP MEDICAL VISIT

I, _____ hereby consent to participating in Group Medical Visits.

The staff has explained to me the activities that occur during the Group Medical Visit and provided me with pertinent handouts. I understand that a provider will be seeing me in the Group Medical Visit session instead of seeing me in my typical one-on-one visit. I understand that my protected health information may be shared with the group by the leader to further my medical treatment. I understand that I will be hearing about the medical care and conditions of others in the group, and I have been assured that my protected health information will continue to remain confidential outside of the Group Medical Visit sessions. I understand that my records are and will continue to be protected under applicable Federal and State Regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996, Title 42 of the Code of Federal Regulations, the Health Information Technology for Economic and Clinical Health Act, and cannot be disclosed without my written consent unless otherwise provided for by law.

I understand that:

____ I will be in a group with a medical care provider and other patients with similar concerns.

____ It is my right to withhold personal information that I do not wish to share with the group.

____ It is my responsibility to respect the privacy of others in the group. I will not share their personal information with anybody else.

____ I may speak to my medical care provider alone if I have additional personal problems to discuss.

____ I can withdraw from the Group Visit at any time for any reason.

____ Not participating will not affect my relationship with my provider or my ability to receive service with Kronos Health.

____ This consent is a supplement to the general consent for services.

My signature confirms that I clearly understand the activities that occur in a Group Medical Visit and that I am willing to participate.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____