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INFORMED CONSENT TO TREATMENT

This and other informed consent documents are used to communicate information about the proposed treatment, to disclose reasonably foreseeable risks, and to provide information about alternative forms of treatment. The informed consent documents should not be considered all-inclusive in describing methods of care and all potential risks. Your provider may provide you with additional or different information based on the facts in your particular case and the current state of medical knowledge.

By signing below, you consent to the rendering of medical care pursuant to the following terms:

1. I understand that my physician is an employee or independent contractor of G. Mark Jenkins, M.D., P.A. d/b/a Cardiac and Vascular Interventional Group ("CVIG"), and I (or the below-named patient) voluntarily consent to be treated by my physician and other CVIG healthcare providers. I consent to all medical treatment, and health care-related services that the CVIG physicians and health care providers deem necessary, this may include diagnostic procedures, therapeutic, imaging, and laboratory services.

2. I understand that I have the right to consent, or to refuse any proposed procedure or therapeutic course.

3. I understand that the practice of medicine and the services or procedures I am receiving today carry some risks and that my CVIG provider has explained my service or procedure to me, including its potential risks. I understand, and have been informed of, the reasonably foreseeable risks. I have been informed about the methods used by CVIG and have had the opportunity to ask questions and express concerns prior to treatment. I wish to rely on the professional and clinical judgment of my CVIG provider during the course of my treatment.

4. CVIG offers certain services via telehealth, which involves the use of electronic communications intended to improve patient care through efficient medical evaluations and management and which shares information such as patient medical records, medical images, live two-way audio and video, and output data from medical devices and audio and video files. If I choose to participate in telehealth interactions with CVIG for my care, then I understand that there are certain risks and limitations of telehealth, including: information transmitted may not be sufficient to allow for appropriate medical decisions to be made by CVIG (e.g., poor resolution of images); delays in medical evaluation and treatment could occur due to deficiencies in or failures of equipment; security protocols could fail, causing a privacy or security breach of personal and/or protected health information; or a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

_____ (*initial*) I have read and understand the above risks and considerations regarding the use of telehealth for my care, and I voluntarily consent to treatment by CVIG with telehealth technology.

5. I specifically authorize release of my medical records, including: alcohol and drug abuse records protected Code 42 of Federal Regulations, Part 2, psychological services records; social services records, including communications made by me to a social worker or psychologist; records of HIV testing including results, records of treatment for AIDS; and records of a communicable disease to (a) my insurance company or third party payer for the purpose of payment of the medical services provided by CVIG; and/or (b) to another health care provider for the purpose of transferring care to another health care provider.

6. I understand and authorize CVIG to communicate with me via email, text message and other electronic communications to allow for more efficient and expedited feedback from CVIG providers. The electronic communications may contain protected health information. The transmission of the electronic communications will most likely be encrypted or secured. I further understand that any electronic communications, such as texts messages, that are transmitted to my personal device, such as my cell phone, may not be stored or maintained in an encrypted or secured manner. While not all-inclusive, the potential risks of CVIG providers communicating with me via text message, email, and other means electronically include, but may not be limited to: (i) the transmission of information may fail,

be delayed or unclear (e.g., problematic or delayed electronic transmission of the information); or (ii) the communication or storage of the information may be unsecure, or security protocols could fail, causing a breach of personal and protected health information.

I understand and have been informed of the potential risks. I have had the opportunity to ask questions and express concerns prior to such communications. I will notify CVIG if I have any concerns or prefer that my CVIG providers do not communicate with me via text message, email or electronically.

7. I understand that if a healthcare provider at my physician's office sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids I (or the below-named patient), may be tested for hepatitis, human immunodeficiency virus (which is the causative agent of AIDS) and syphilis. I understand that any test result obtained under these circumstances does not become part of my (or the below-named patient's) medical record.

8. I understand that CVIG does not assume responsibility for safekeeping of any personal property, which I have with me at the time of my off a visit and hereby release CVIG from responsibility for all personal property, including but not limited to currency, jewelry, electronic device medical equipment, personal documents.

9. I agree to the release of my medical information to my insurance company or third party payor and in consideration of the health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CVIG all right, title, and interest in and to any third-party) benefits due from any and all insurance policies and/or responsible third-party payors for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payor, and I understand that I am financially responsible to CVIG for services not covered or payable by my insurance company irrespective of any dispute between my insurance company and myself.

10. **Medicare/Medicaid Assignment of Benefits: (Do not complete unless you receive Medicare/Medicaid health care benefits)**

_____ (*initial*) I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

_____ (*initial*) I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

11. **Notice of Privacy Acknowledgement**: CVIG's Notice of Privacy Practices provides information about how CVIG may use and disclose my protected health information. A copy of the current Notice is posted in the waiting room and one our website at www.thecvig.com. You have the right to review the Notice before signing this acknowledgment, and you have the right to request a copy for your records. The Notice contains the effective date and as provided in Notice, the terms of our Notice may change.

I acknowledge that I have received CVIG' s Notice of Privacy Practices. _____
(Patient signature required)

This consent form has been fully explained to me and I understand its contents and the consents made by me. By signing my name at the bottom of this form, I am consenting to CVIG's treatment for my present and future care. *If applicable, I have the legal right to select and authorize healthcare services for the patient named below, and I authorize CVIG to perform the treatment as outlined above to this patient.*

Patient Name: _____ Patient Date of Birth _____
(Please Print Name)

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____