MANTILLA SURGICAL | COLORECTAL & PELVIC HEALTH

PATIENT CONSENT, TELEHEALTH, FINANCIAL & RECORDS AUTHORIZATION

Patient Consent Packet

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Patient name / Nombre del paciente: _____

Date of birth / Fecha de nacimiento: _____ Date / Fecha: _____

1. General Consent for Evaluation and Treatment

I voluntarily request and consent to evaluation and medically appropriate care by Mantilla Surgical Colorectal & Pelvic Health and its authorized clinical personnel. This includes care delivered in person and, when appropriate, through telehealth.

I understand that routine evaluation may include history, physical examination, review of records, and noninvasive or routine office-based assessments. If a procedure, surgery, sedation, or other intervention requiring specific informed consent is recommended, its nature, expected benefits, material risks, alternatives, and the opportunity to ask questions will be addressed separately before that procedure.

I understand that medicine is not an exact science and no guarantee has been made regarding the outcome of evaluation or treatment. I agree to provide accurate and complete information about my health, medications, allergies, and changes in my condition. I understand that treatment may involve risks, including adverse medication reactions or interactions with other medications or supplements.

I understand that I may ask questions and may decline or withdraw consent for non-emergency care, subject to the consequences of declining recommended evaluation or treatment.

☐ I have read and agree to the General Consent for Evaluation and Treatment.

2. Telehealth Consent and Scope

I understand that I may occasionally consult with my healthcare team through a secure telehealth platform. Telehealth uses electronic communications, including interactive video, audio, and secure messaging, to evaluate, diagnose, and manage health concerns without requiring travel to the clinic.

I understand that telehealth has potential risks and limitations, including: the video connection may fail or stop working; the video image or information transmitted may not be clear enough to be useful; and the provider cannot perform a hands-on physical examination. An in-person visit may be necessary if medically indicated. Telehealth may provide access to specialized care and follow-up without travel.

Telehealth is not intended for medical emergencies. For a medical emergency, severe pain, or a surgical complication, call 911 or go to the nearest emergency department. For a mental health crisis or emotional support, call or text 988.

3. Electronic Communication Preferences and Consent

Please tell us how we may contact you. Standard email and SMS/text messaging may have privacy risks. Do not use routine messaging for emergencies.

☐ May call mobile ☐ May call home/other ☐ May leave voicemail with callback information

☐ May send appointment/reminder texts ☐ May send administrative texts ☐ May send portal messages

☐ May email appointment/administrative information ☐ Do not email me

Preferred phone: _____ Preferred email: _____

Mantilla Surgical may use email and SMS/text messaging for appointment reminders, portal notifications, billing statements, and care-coordination updates. I consent to receive these communications at the phone number and email address I provide. Standard data and messaging rates may apply. I may opt out of text messages by replying STOP or by contacting the office. Electronic communications may not be fully secure; I understand and accept the privacy risks associated with the communication methods I select.

4. People Authorized to Receive Information

I authorize the practice to discuss my care, appointments, and/or billing with the person(s) listed below, limited to the permissions indicated. This does not authorize disclosures beyond my stated permission or where another specific authorization is legally required.

Name: _____ Relationship: _____ Phone: _____

May discuss: _____

Name: _____ Relationship: _____ Phone: _____

May discuss: _____

For “May discuss,” indicate: medical care / appointments / billing / all. I may revoke this permission by notifying the practice in writing, except to the extent action has already been taken in reliance on it.

5. Consent to Obtain Medication History

To help ensure my safety and prevent adverse drug interactions, I authorize Mantilla Surgical Colorectal & Pelvic Health and its affiliated providers to electronically query, view, and download my medication fill history. I authorize my pharmacies, health plans, and other healthcare providers to disclose prescription information to the practice. I understand this information will be stored in my electronic medical record.

6. HIPAA Notice of Privacy Practices — Acknowledgment of Receipt

I acknowledge that I have been offered or provided access to the Mantilla Surgical Colorectal & Pelvic Health Notice of Privacy Practices, which explains how my health information may be used and disclosed and describes my privacy rights. Signing this acknowledgment does not authorize uses or disclosures beyond those permitted by law and the Notice of Privacy Practices.

☐ I received/accessed the Notice of Privacy Practices. ☐ I declined a copy because I already have access to it.

Practice use if acknowledgment is not obtained: ☐ Patient declined to sign ☐ Emergency ☐ Unable to obtain ☐ Other: _____

7. Financial Agreement, Responsibility, and Assignment of Benefits

By seeking care at Mantilla Surgical Colorectal & Pelvic Health, I understand and agree to the following financial responsibilities and insurance policies.

Assignment of benefits: I assign, transfer, and set over to Mantilla Surgical Colorectal & Pelvic Health, to the extent permitted by law and my plan, my rights and interest in medical reimbursement benefits under my insurance policy for services provided by the practice. I authorize release of medical or other information reasonably necessary to process claims. This assignment remains in effect until revoked by me in writing. A photocopy may be treated as valid as the original where permitted.

Direct payments to patient: If my insurer sends me payment for services provided by the practice, I agree to promptly endorse and forward the payment to the practice within ten (10) days of receipt. If I do not forward the payment, the balance may become my personal responsibility and my account may be referred for collection, subject to applicable law.

Financial responsibility: I am ultimately financially responsible for charges not paid by insurance or another payer, including copayments, coinsurance, deductibles, non-covered services, and self-pay amounts, subject to applicable law and my payer contract. I will provide accurate insurance information and notify the practice of changes. Estimates do not guarantee final charges or insurance payment.

Out-of-network services and billing: If the practice is out of network with my plan, the billing team may work with my insurer to process claims and maximize benefits. Where required by the federal No Surprises Act, a separate notice and consent and/or a Good Faith Estimate will be provided. I understand that I may have options, including choosing an in-network provider, depending on the circumstances and applicable law. Facilities, anesthesia groups, laboratories, pathology groups, imaging providers, or other clinicians may bill separately.

☐ I acknowledge the practice financial policy and my responsibility for amounts I owe.

8. Appointment Cancellation and No-Show Policy

To support timely and efficient care, the practice requests at least 24 hours' notice to cancel or reschedule an appointment. Notice may be sent by email, text message, or through the patient portal no later than 24 hours before the scheduled appointment.

A late cancellation is an appointment canceled or rescheduled with less than 24 hours' notice. A no-show is failure to attend a scheduled appointment without prior notice.

A $50.00 fee may be charged for each late cancellation or no-show. The practice may charge the fee to the payment method on file where permitted. Outstanding fees may need to be paid before future appointments or treatments are scheduled. The practice may waive a fee in exceptional circumstances at its discretion; waiver is not guaranteed.

9. Optional Authorization to Obtain Outside Medical Records

Complete this section if you want Mantilla Surgical Colorectal & Pelvic Health to request records from another clinician or facility. This authorization is optional and may be replaced by a separate HIPAA-compliant authorization when required.

Provider/Facility: _____

Phone/Fax: _____

Records requested: ☐ Office notes ☐ Operative reports ☐ Colonoscopy/endoscopy ☐ Pathology ☐ Imaging ☐ Labs ☐ Other: _____

Date range: From _____ to _____ Purpose: Continuity of care / evaluation and treatment

I authorize the provider/facility named above to disclose the records selected to Mantilla Surgical Colorectal & Pelvic Health. I understand I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. Unless a shorter period is required by law or specified here, this authorization expires one year from the date signed or upon completion of the stated purpose, whichever occurs first.

10. Patient Attestation and Signature

By signing below, I acknowledge that I have reviewed the applicable sections of this document, had an opportunity to ask questions, and understand that permissions and authorizations may be revoked when permitted by law by notifying the practice in writing. I acknowledge the consents and permissions I selected above.

☐ General treatment consent ☐ Telehealth consent ☐ Electronic communication consent/preferences

☐ Medication history authorization ☐ HIPAA Notice acknowledgment ☐ Financial agreement acknowledged

☐ Outside-record authorization completed, if applicable

Patient/Legal Representative Signature: _____ Date: _____

Printed Name/Relationship (if representative): _____ Date of Birth: _____

Witness/Practice Representative: _____ Date: _____

FOR PRACTICE USE — Reviewed by: _____ Date: _____

Medication reconciliation: ☐ Completed ☐ Pending Allergies verified: ☐ Completed ☐ Pending

Outside records needed: ☐ No ☐ Yes: _____ Follow-up items: _____