BelRed Family Medicine PLLC dba Advanced Family Medicine PLLC
2007 152nd Ave NE, Redmond, WA 98052 | Phone 425-453-6838 | Fax 425-456-0106

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Patient Name: _____ **Date of Birth:** _____

1. Consent to Treatment Initials _____

I consent to examination, diagnostic tests, and treatment by the providers and staff of BelRed Family Medicine PLLC dba Advanced Family Medicine PLLC (the "clinic"). I may ask questions about my care and may refuse any treatment.

2. Acknowledgement of Notice of Privacy Practices (HIPAA) Initials _____

By signing this document, I acknowledge that I have received or have been offered a copy of BelRed Family Medicine PLLC dba Advanced Family Medicine PLLC's *Notice of Privacy Practices*.

- I understand this notice describes how my health information may be used and disclosed for treatment, payment, and healthcare operations.
- I understand that I have the right to request restrictions on how my data is used, though the practice is not required to agree to all requested restrictions.
- I understand the clinic may change its privacy practices, and I may request a copy of the current notice at any time.

3. Insurance Billing & Assignment of Benefits Initials _____

I authorize the clinic to bill my insurance, to release the information needed to process claims, and to receive benefits payable directly to the clinic. I am responsible for copays, deductibles, coinsurance, and non-covered services.

4. Consent for AI Clinical Documentation (AI Scribe) Initials _____

With my consent, audio of my visit is recorded and processed by a HIPAA-compliant AI tool (the vendor is under a Business Associate Agreement) to create a draft note that my provider reviews. The audio is used only for documentation and is not kept longer than needed. I may decline, or stop the AI Scribe, at any visit without affecting my care. This serves as my notice and consent under Washington law (RCW 9.73.030) for the recording of private conversations, and anyone accompanying me will be informed.

☐ **I agree** ☐ **I decline**

5. Consent for Electronic Communication (Text & Email) Initials _____

I authorize BelRed Family Medicine PLLC dba Advanced Family Medicine PLLC to communicate with me by SMS text message and email regarding my care (including appointment reminders, billing statements, and general health notifications). I understand standard text and email are not fully secure, and are not for emergencies (call 911). Message and data rates may apply. I may opt out at any time by replying STOP or by telling the office.

Mobile Phone: _____ Email Address: _____

Preferred contact method: ☐ Secure patient portal (preferred) ☐ Phone/voicemail ☐ Text message

☐ OK to leave a detailed voicemail

6. Authorized Contacts (Optional) Initials _____

I authorize the clinic to discuss my medical care, appointments, and billing information with the following individuals (e.g., spouse, parent, caregiver):

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

7. Appointment Cancellation Policy Initials _____

Appointments cancelled less than 24 hours in advance, or missed without notice (no-show), will be charged a $60 fee.

8. Financial & Administrative Policy (available on request) Initials _____

I acknowledge the clinic's Financial & Administrative Policy, which is available on request.

Duration: This consent remains in effect until I revoke it in writing. Revocation does not affect actions already taken.

SIGNATURE By signing below, I acknowledge that I have read and understand the above policies and grant my consent. I was given the option to review these documents and to get copies.

Patient printed name: _____ **Date:** _____

Patient signature / personal representative: _____

Representative printed name (if signed by a representative): _____ Relationship to patient: _____

OFFICE USE ONLY *If acknowledgment could not be obtained, please document the efforts made:*

☐ Patient refused to sign ☐ Emergency prevented signature ☐ Other: _____

Staff initials: _____ **Date:** _____