



PATIENT CONSENT & ACKNOWLEDGMENT

Premier Primary Care LLC

1. PATIENT INFORMATION

Patient Full Legal Name: _____

Date of Birth: _____

Address: _____

City / State / ZIP: _____

Telephone: _____

Email: _____

☐ Check this box to opt out of marketing texts

2. GENERAL CONSENT TO MEDICAL CARE

I voluntarily consent to evaluation and treatment by Premier Primary Care LLC and its physicians, nurse practitioners, physician assistants, clinical staff, and other authorized healthcare professionals involved in my care.

I understand that this general consent covers medically appropriate examinations, assessments, diagnostic testing, medication management, treatment, care coordination, and other routine services related to my condition. If a procedure or service requires a separate informed consent, I will be given additional information and asked for that consent before the procedure when required.

I understand that healthcare outcomes cannot be guaranteed. I may ask questions about my care, proposed tests or treatments, alternatives, risks, and expected benefits. I may refuse or stop treatment, subject to applicable law and the clinical consequences explained to me.

I understand that Premier Primary Care LLC may be required or permitted by law to make certain reports or disclosures, including disclosures concerning abuse, neglect, or serious threats to health or safety.

3. TELEHEALTH CONSENT

When clinically appropriate, I consent to receiving healthcare through telehealth, telephone, video, or other electronic communication methods used by Premier Primary Care LLC. I understand that telehealth may involve limitations compared with an in-person examination, including technology failures or incomplete information.

I may ask questions about telehealth and may request an in-person evaluation when clinically appropriate. Telehealth is not an emergency service. If I believe I am experiencing a medical emergency, I should call 911 or go to the nearest emergency department.

☐ I consent to telehealth services when clinically appropriate.

4. COMMUNICATION PREFERENCES

Premier Primary Care LLC may contact me regarding appointments, care coordination, test results, billing, insurance matters, and other communications related to my care using the contact information I provide, subject to applicable privacy requirements and my communication preferences.

☐ Telephone / voicemail



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- ☐ Text message for non-marketing healthcare communications
- ☐ Email
- ☐ Mail

I may request reasonable confidential communications or ask Premier Primary Care LLC to contact me by a different method or at a different location.

5. CHRONIC CARE MANAGEMENT (CCM)

Chronic Care Management (CCM) is intended for eligible patients with multiple chronic conditions and supports care between visits. Services may include development and maintenance of a personalized care plan, medication management, care coordination with other healthcare professionals, and access to the care team as described by the program.

I understand that, when I participate in CCM:

- CCM services may be billed monthly when program requirements are met.
- Applicable Medicare or insurance deductibles, coinsurance, or copayments may apply.
- Only one practitioner or organization may furnish and bill Medicare for CCM services for me during a calendar month.
- I may stop CCM services at any time by notifying Premier Primary Care LLC.
- My health information will be handled in accordance with applicable privacy and confidentiality requirements.

- ☐ I CONSENT to participate in CCM services when I am eligible and enrolled.
- ☐ I DECLINE CCM services at this time.

Patient Initials: _____

6. REMOTE PATIENT MONITORING (RPM)

Remote Patient Monitoring (RPM) allows eligible patients to transmit health information from connected or digital devices for review by the healthcare team. Depending on the care plan, devices may include a blood pressure monitor, pulse oximeter, weight scale, glucose-monitoring device, or other approved equipment.

I understand that:

- RPM supports my medical care but does not replace regular clinical care or emergency services.
- RPM services are not monitored 24 hours a day, 7 days a week. For an emergency, I should call 911 or go to the nearest emergency department.
- I should use RPM equipment only as instructed and should not intentionally alter, damage, misuse, or tamper with the equipment or transmitted data.
- Data transmission may be delayed, incomplete, or interrupted because of equipment malfunction, internet service, cellular connectivity, or improper device use.
- Applicable deductibles, coinsurance, copayments, or other patient financial responsibility may apply.
- I may stop participating in RPM by notifying Premier Primary Care LLC.
- Equipment supplied by Premier Primary Care LLC or its designated program/vendor remains the property of the supplying entity unless I am told otherwise, and I agree to return loaned equipment when participation ends or when requested.

- ☐ I CONSENT to participate in RPM services when I am eligible and enrolled.
- ☐ I DECLINE RPM services at this time.

Patient Initials: _____



7. ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I authorize payment of applicable insurance benefits, including Medicare and/or Medicaid benefits when applicable, directly to Premier Primary Care LLC or the healthcare professional or entity furnishing covered services on my behalf, to the extent permitted by my plan and applicable law.

I understand that I am responsible for amounts that are my responsibility under my insurance coverage or applicable law, including deductibles, coinsurance, copayments, non-covered services, or other valid patient-responsibility amounts. I authorize Premier Primary Care LLC to submit information reasonably necessary for billing and payment as permitted by law.

8. HIPAA TREATMENT, PAYMENT & HEALTH CARE OPERATIONS CONSENT

I acknowledge that Premier Primary Care LLC may use and disclose my protected health information for treatment, payment, and health care operations as permitted by the HIPAA Privacy Rule and described in the Premier Primary Care LLC Notice of Privacy Practices. This section is a consent for those activities and is not a HIPAA authorization for a use or disclosure that otherwise requires a specific authorization.

I understand that I may request restrictions on certain uses or disclosures and may request confidential communications. Premier Primary Care LLC is not required to agree to every requested restriction, except where applicable law requires otherwise.

☐ I acknowledge and consent to the use and disclosure of my PHI for treatment, payment, and health care operations as described above.

9. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that Premier Primary Care LLC has offered or provided me access to its Notice of Privacy Practices, electronically or on paper. I understand that the Notice describes how my protected health information may be used and disclosed and explains my privacy rights.

I understand that signing this acknowledgment does not authorize special uses or disclosures of my health information beyond those permitted by law or separately authorized by me.

☐ I acknowledge receipt or availability of the Premier Primary Care LLC Notice of Privacy Practices.

☐ Patient declined or was unable to sign the NPP acknowledgment (staff document reason below).

Reason, if applicable: _____

10. OPTIONAL PERMISSION TO DISCUSS CARE WITH DESIGNATED PERSON(S)

Complete this section only if you want Premier Primary Care LLC to discuss specified information with another person. Leaving this section blank does not affect your treatment or benefits.

Name of Person: _____

Relationship: _____

Telephone: _____

Information I permit Premier Primary Care LLC to discuss:

- ☐ Appointments / scheduling
- ☐ General care coordination
- ☐ Medication information
- ☐ Billing / insurance
- ☐ Test or laboratory results



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☐ Other: _____

This permission expires one year from the date I sign this form unless I write a different expiration date below. I may revoke this permission in writing, except to the extent action has already been taken in reliance on it. This optional permission does not replace a separate authorization when one is required by law.

Different expiration date/event (optional): _____

11. PATIENT RIGHTS & IMPORTANT ACKNOWLEDGMENTS

- I have had an opportunity to ask questions about this form.
- I understand that separate informed consent may be required for certain procedures, services, or disclosures.
- I understand that I may request a copy of this signed form.
- I understand that I may update my communication preferences and marketing-text preference by contacting Premier Primary Care LLC.
- I understand that the Notice of Privacy Practices is available separately and may be requested at any time.

12. PATIENT / REPRESENTATIVE SIGNATURE

By signing below, I certify that I have read or had this form explained to me, have had an opportunity to ask questions, and voluntarily agree to the consents and acknowledgments I selected above.

Patient Name: _____

Patient Signature: _____

Date: _____

Time: _____

13. PERSONAL REPRESENTATIVE / LEGAL REPRESENTATIVE

Complete this section if someone other than the patient is signing. Premier Primary Care LLC may request documentation of the representative's authority when appropriate.

Representative Name: _____

Relationship to Patient: _____

- ☐ Parent / Legal Guardian
- ☐ Healthcare Power of Attorney
- ☐ Personal Representative
- ☐ Executor / Administrator of Estate
- ☐ Other: _____

Representative Signature: _____

Date: _____

14. PRACTICE USE (OPTIONAL)

Staff/Witness Name: _____

Staff/Witness Signature: _____

Date: _____