PATIENT CONSENT AND ACKNOWLEDGMENT

Electronic health records, AI-assisted documentation, telehealth, and text messaging

Patient information

Patient name _____ **Date of birth** _____

Electronic health record consent

Linda S. Falconio, M.D. and Johanna Morofski, P.A. are implementing CGM Aprima, an electronic health record (EHR) system. The system supports coordinated care and may be used to check insurance eligibility, benefits, and care history.

I consent to Linda S. Falconio, M.D. and Johanna Morofski, P.A. electronically obtaining my prescription and medical history information through their electronic health record system.

Notice of AI-assisted documentation

To help provide attentive care, our practice may use ambient AI technology to securely document a visit. The tool transcribes the conversation and creates a clinical summary, allowing the provider to spend more time listening and engaging with the patient. Data is handled in accordance with applicable privacy and security requirements. If I prefer that this tool not be used during my appointment, I may tell the front desk or my provider.

Telehealth consent

By checking the box below, I confirm that I have reviewed this form, understand its content, accept the risks and benefits of telehealth services, and consent to receive telehealth services. If I am signing for a minor, incapacitated person, or other legally dependent patient, I certify that I have legal authority to act for the patient, including authority to consent to medical services.

[ ] I agree to receive telehealth services.

SMS/text message consent

[ ] SMS/text consent **Patient Phone Number:** _____

By checking this box, I agree to receive SMS/text updates about my appointments and telehealth visits from The Doctor's Office at the patient phone number entered above. Message frequency may vary. Message and data rates may apply. Reply STOP to opt out or HELP for help.

Important: Telehealth consent and SMS/text consent are separate choices. Declining SMS/text messages does not withdraw any other consent documented on this form.

Signature

Patient or authorized representative signature _____ **Date** _____

Printed name _____ **Relationship to patient (if applicable)** _____

The Doctor's Office
161 Thunder Dr Ste 102, Vista, CA 92083
Phone: +1 760-631-4000
Email: insurance@thedoctorsoffice.net
Website: www.thedoctorsoffice.net