William James Brooks, DO, PC
Board Certified - Osteopathic Manipulative Medicine
Diplomate – Integrative and Holistic Medicine

MEDICAL CARE AGREEMENT

Effective 3-1-2022

Your privacy is important. Please review William James Brooks, DO, PC's Notice of Privacy Practices. If you do not understand this medical care agreement, please ask questions. William James Brooks, DO, PC cannot accept changes to this medical care agreement.

I _____or my legal representative_____

agree to the following terms of encounter with William James Brooks, DO, PC: that

1. **Medical Care:** I (or the patient) consent(s) to receive evaluation and management services provided by William Brooks, DO that may include but are not limited to physical examination along with ordering of laboratory tests, imaging studies, and/or other diagnostic investigations and to treatment as prescription of medications, nutritional supplements, counseling, education, and/or referral to other health care professionals. I (the patient) further consent(s) to treatment which may include but is not limited to physical medicine services as manual/manipulative medicine procedures and as prescription of therapeutic exercises.

2. **Contraband:** any hazardous and/or illegal article including but not limited to drugs, alcohol, and weapons may not be brought onto William James Brooks, DO, PC's premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.

3. **Photographs/Videos/Taping:** I (the patient) understand(s) and agree(s) that

   - Photographs and/or videos may be taken of me (him or her) upon admission for identification purposes, security, and/or quality improvement purposes.

   - Voice mail I leave with Dr. Brooks may be retained as part of my medical record.

   - Photos/videos obtained in the course of my care—contingent upon my (the patient's) explicit permission—may also be retained as part of my medical record.

   I (the patient) further consent(s) that all photographs, videos, and audio tape/files will remain the property of William James Brooks, DO, PC and that I (the patient) will not audiotape, videotape or take pictures of other patients and will not audiotape, videotape, or take pictures of William Brooks, DO or his staff without Dr. Brooks' permission.

4. **Dismissal from William James Brooks, DO, PC:** William Brooks, DO may dismiss you (the patient) for reasons that include but are not limited to excessive no-shows, non-compliance with treatment recommendations, and/or disruptive/inappropriate behavior.

5. **Teaching:** William Brooks, DO may provide training for health care providers and students and that these persons may observe care given to the patient by William Brooks, DO. I (the patient) consents to some services being provided by these persons in training under the direct supervision and instruction of William Brooks, DO.

6. **Research:** Research leads to improved medical care. William Brooks, DO is a Designated Campus Colleague with the University of Arizona Department of Orthopedic Surgery and an Adjunct Research Scientist with the Andrew Taylor Still Research Institute. Thus, he may engage in collaborative research with those institutions and potentially the University of Minnesota Department of Orthopedic Surgery.

   Any health care research involving my information requires prior review and approval from an Institutional Review Board (IRB). An IRB is charged with the protection of research subjects and helps ensure that research is conducted responsibly. Any published research will ***not identify specific subjects*** as all "patient identifying information" will be removed (deidentified) prior to data analysis. (The list of the 18 personal identifiers is available upon request.)

   Any information disclosed for research purposes may include any portion of or my entire medical record. No billing or medicolegal information will be disclosed.

   I have the right to revoke this authorization at any time by written, signed, and dated notification.

   This authorization will not expire unless I revoke my authorization in writing.

   I understand that my medical care, including treatment or payment, will not be compromised or conditioned by my choice to not give my permission to share my deidentified information for research purposes.

   Although no patient identifying information will be published, there is a potential that the information disclosed for collaborative research pursuant to this authorization may be subjected to redisclosure by the recipient and thus, no longer protected. Dr. Brooks ensures that reasonable assurances will be received prior to any research analyses that the recipient of the protected health information will protect that information.

   Unless I (the patient) signify with my initials that I do ***not*** give my permission to share my deidentified information, I authorize the sharing of my information with external health researchers in accordance with the law. Please initial here if you do NOT give permission to share deidentified information: _____

7. **Release of Information:** I (the patient) acknowledge(s) and agree(s) that medical information (including that regarding alcohol/drug abuse and communicable disease including HIV) and/or financial records may be provided to the following:

    - Healthcare providers or their agents who are providing or have provided health care to me (the patient); any individual or entity responsible for payment of William Brooks, DO's charges; health care providers or organizations accrediting and/or conducting utilization review, quality assurance, and/or peer review of William James Brooks, DO, PC, and/or William Brooks, DO; William James Brooks, DO, PC's and/or William Brooks, DO's legal representatives and professional liability carrier.

    - Individuals and organizations engaged in medical education and research, provided only deidentified information may be released for use in medical studies and research as further detailed in Paragraph 6, above.

    - Individuals and entities as specified by federal and state law and/or in William James Brooks, DO, PC Notice of Privacy Practices.

8. **Communication:** call this number_____

- ___Okay to leave a message.
- ___Do ***not*** leave a message.
- ___Do ***not*** speak to family members.

I authorize the following individuals to inquire and receive verbal information regarding my care:_____

9. **Term of Agreement:** This agreement shall remain in effect as long as I (the patient) am seeking services from William James Brooks, DO, PC. I (the patient) may be asked to sign a new agreement every 12 months. This release shall continue for so long as the medical and/or financial records are needed for payment, diagnosis, treatment, or medical care operations.

ACKNOWLEDGMENT I have received the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement. I hereby agree to the terms set forth above, unless otherwise indicated.

Patient/Authorized Representative_____Relationship_____

Witness_____Time/Date_____