

John E. Toerge, DO, LLC

John E. Toerge, DO, FAAPMR
5410 Edson Lane, Suite 350
Rockville, Maryland 20852
Telephone number: (301) 377-2661
Fax number: (240) 765-6340
Email address: john@johntoergedo.com
Website: www.johntoergedo.com



Consent and Authorization for Medical Treatment:

___ **Electronic Practice:** We are a 100% electronic practice. So that we can serve you more efficiently, please email all forms back to us in the same format you received them. This will permit us to spend more time focusing on you and your concerns during the visit versus time spent reviewing factual data. Of course, we will focus our attention on the issues that are most meaningful and pressing for you. Both of us will benefit from addressing your significant health concern(s). Thank you for your full participation in this effort.

___ **General Consent for Medical Treatment:** In advance of any treatment or procedure(s), I authorize John E Toerge, DO to treat and/or perform procedure(s) that may include routine diagnostic examination(s), radiological testing, laboratory procedures, medication prescription and manual medicine treatment(s). This includes but is not limited to: general medical physical examination, neurological examination, static and dynamic postural testing, gait evaluation, range of motion, manual muscle testing, functional capacity assessment, treatment with Osteopathic Manipulative Treatment (OMT) or Osteopathic Manual Medicine (OMM) or other techniques mutually agreed by Dr. Toerge and me. I understand that I may ask to have any intervention discontinued, if I am uncomfortable physically or emotionally with that procedure. It is my obligation to give immediate feedback to Dr. Toerge regarding these circumstances.

___ **Electronic Prescription (e-Prescribing) of Medications:** Electronic prescriptions of medications integrates the patient, healthcare provider and pharmacist to provide the safest prescribing situation for everyone involved. With the number of medications available and potential recalls or other safety issues, e-prescribing provides a systematic approach to improve quality and safety of your prescription. As part of this system, **Drchrono** (our Electronic Health Record, EHR) uses **Surescript** as its electronic prescription monitoring system. I give my consent and authorization for Dr. Toerge to use Surescript to access my complete medications profile, and I will use e-prescribing for any prescriptions that Dr. Toerge may generate on my behalf.

___ **Clinical Photography:** Clinical photography is considered a routine practice in the care and treatment of patients and is covered within this consent to treat. Since we will not use the patient's social security number for identification purposes, patient photographs are used as a form of identification within the patient's individual electronic medical record (EMR). Video will not be used except if the patient's personal electronic device is used with the patient's consent for patient education, exercise instruction or personal message that will stay within the control of the patient - therefore not a Health Insurance Portability and Accountability Act (HIPAA) issue. Any disclosure of clinical photography is

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considered the release of protected health information (PHI) and must follow all applicable HIPAA policies. I authorize the use of photography within the context noted in this paragraph.

____ **Collaborative Practice:** Since Dr. Toerge's practice is primarily electronic, it lends itself to fuller patient-physician collaboration. Information exchange can be facilitated. Prior to your visit, you will be asked to complete an online form to provide interim information and focus the current visit. This helps both the patient and physician anticipate the outcome of that visit. This also helps dedicate time to issues that are most significant to either the patient and/or the physician. Respect for time and scheduling should be enhanced. The office environment provides access to other healthcare providers who may significantly contribute to your care. Use of these professionals will enhance the collaboration for your healthcare. This is the idea of a collaborative practice. I understand that there is a mutual obligation to participate in this collaboration for maximum benefit to me.

Together, Dr. Toerge and I will provide each other pertinent information and findings to facilitate the best outcome from these visits or interactions. However, I understand that medicine is not an exact science, and I affirm that no guarantees, actual nor implied, have been made to me.

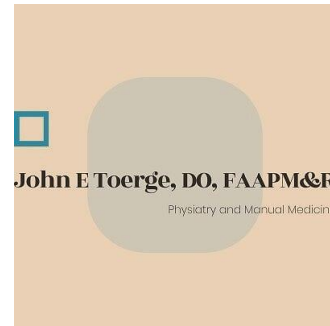
____ **Other Physician Relationships:** I understand that I must have a Primary Care Physician (PCP) to treat my general medical conditions. The name of the PCP must be available before I can make an appointment with Dr. Toerge. If I am taking controlled substances, I will also have a direct relationship with a Pain Management Specialist. Both physicians will receive visit notes from Dr. Toerge to facilitate collaboration. Medication management will be coordinated by the PCP and controlled substances will be recommended and monitored by the Pain Management Specialist. Testing and monitoring of controlled substances will be done by either the PCP or the Pain Management Specialist. This is my obligation before I can initiate a visit with Dr. Toerge.

____ **Compensation for Services Rendered:** I understand that Dr. Toerge's practice is a fee-for-service practice that will be out-of-network for my insurance carrier. I will be responsible for full payment via credit card at the time of service. In addition, I will be personally responsible for seeking reimbursement from my insurance carrier. A superbill will be provided to me at the end of the office visit, and I will have access to the clinical note pertaining to that visit via the patient portal. Dr. Toerge's office will not accept payment directly from any insurer. Insurance checks will be returned to the insurance company.

____ **Medicare Opt-out:** I understand that Dr. Toerge has opted-out of Medicare. This means Dr. Toerge will not bill Medicare nor accept reimbursement from Medicare. Further, I cannot expect payment nor reimbursement from Medicare, if I seek treatment with Dr. Toerge. I may have the ability to seek reimbursement from my supplemental benefit insurer with denial of payment by Medicare, but no

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representation can be made that will occur even with supporting documentation. Dr. Toerge's office will not accept payment directly from Medicare. Medicare checks will be returned to Medicare.

_____ Cancellation Policy: Since visit availability is limited and significant prior work goes into each visit, a cancellation policy is necessary for the patient who is scheduled and the patients who are waiting to be scheduled. If you cancel the appointment with 24 hour or greater notice, this will be considered adequate notice. Cancellation with less than 24 hour notice or day of service will result in a cancellation fee of \$50 assessed at the next visit. Missed appointments and/or failure to keep appointments may result in discontinuation of online scheduling privileges at the discretion of the practice.

I have read this document in its entirety. I understand each paragraph, and any questions I may have had were clarified for me. I acknowledge the fact and intent of the document designated by my signature:

Printed Patient Name Patient Signature and Date

Printed Witness Name Witness Signature and Date