



Primary Medicine of Sunnyvale

General Consent for Care and Treatment

- **Patient Full Name:** _____
- **Date of Birth:** //
- **Phone Number:** _____
- **Email Address:** _____

1. Consent for Treatment

I voluntarily consent to the medical care and treatment provided by the physicians, nurse practitioners, physician assistants, and clinical staff of **Primary Medicine of Sunnyvale**. I understand that this care may include, but is not limited to, routine physical examinations, diagnostic testing, laboratory procedures, immunizations, and prescribed medications. I acknowledge that no guarantees have been made to me regarding the results of any examination or treatment.

2. Use of Artificial Intelligence (AI) and Voice Recognition Technologies

I understand that **Primary Medicine of Sunnyvale** utilizes advanced technologies, including artificial intelligence (AI) and automated voice recognition systems, to improve the quality and efficiency of care.

- **Clinical Documentation:** I consent to the use of voice-to-text and AI ambient scribes during my appointments. These systems listen to the conversation between myself and my provider to securely generate clinical notes for my medical record.
- **Data Security & Privacy:** I understand that these tools comply with federal privacy laws (HIPAA). Audio recordings are used strictly to generate the text summary and are securely processed, encrypted, and deleted according to clinic and vendor privacy policies.
- **Provider Oversight:** I acknowledge that my healthcare provider reviews, edits, and finalizes all AI-assisted notes to ensure accuracy before they become part of my permanent medical record.

3. Minors and Dependents

If the patient is a minor (under 18 years of age) or requires a legal guardian, I, as the parent or legal guardian, authorize the healthcare providers of **Primary Medicine of Sunnyvale** to examine and treat the patient.

- **Authorized Caregivers:** I also authorize the following individuals to bring the patient to their appointments and/or consent to treatment on my behalf in my absence:
 - Name/Relationship: _____
 - Name/Relationship: _____

4. Financial Responsibility and Insurance

I understand that I am ultimately responsible for all charges associated with my medical care. I authorize **Primary Medicine of Sunnyvale** to submit claims to my insurance provider and request payment of benefits directly to the clinic. I acknowledge that I am responsible for any deductibles, copayments, coinsurance, or non-covered services as determined by my insurance plan.

5. Acknowledgment of Privacy Practices (HIPAA)

I acknowledge that I have been given the opportunity to review or receive a copy of the **Primary Medicine of Sunnyvale** Notice of Privacy Practices. This notice explains how my protected health information (PHI) may be used and disclosed, and how I can access my medical records.

6. Electronic Communications (Optional)

I authorize **Primary Medicine of Sunnyvale** to contact me regarding appointments, test results, and billing using the following methods:

- **Phone / Voicemail** at my provided number
- **Secure Text Messages** at my provided number
- **Email** at my provided address

Patient/Guardian Signature

By signing below, I certify that I have read and fully understand the contents of this consent form, and I voluntarily consent to the terms outlined above.

Patient or Legal Guardian Signature: _____

Printed Name: _____

Date: // _____

Relationship to Patient: Self Parent Legal Guardian Other: _____