ST. LOUIS CANCER CARE CONSENT FORM
South Kennerly office)

PATIENT CONSENT FORM– CONFIDENTIAL

Patient Name _____

Patient DOB:_____

- **Consent to Treatment:** I hereby authorize the employees, agents and staff of St. Louis Cancer Care to perform, and hereby consent to such medical treatment and examinations as may in the opinion of the patients' physician be necessary. This also includes any services related to nutrition support/counseling and activity level and temperature monitoring.
- **Consent to Navigation Services:** I consent to receive principle navigation services provided by St. Louis Cancer Care employees. Such navigation services may include, but are not limited to, providing informational assistance, financial assistance, and/or social and support services. By signing this agreement, I understand and agree to these services.
- **Principal Care Management (PCM):** PCM services are available to patients with one serious chronic condition. Medicare defines a serious chronic condition as one that is expected to last for at least 3 months, is the focus of ongoing medical care, and places the patient at significant risk of hospitalization, functional decline, or death. Benefits of PCM Services include:
    - 24/7 access to a care provider familiar with your chronic condition.
    - A personalized care plan focused specifically on managing your principal chronic condition, available in print or electronically.
    - Regular check-ins and follow-up to support treatment goals and symptom management.
    - Coordination with specialists, pharmacists, and community-based services involved in your care.
    - Transition support after hospital or skilled nursing facility discharges related to your chronic condition.
    - Medication management and oversight specific to your chronic illness.
    - Should you desire to receive these services through your provider, he/she agrees to only bill your insurance for services once per 30-day billing cycle. The standard Medicare Part B cost-sharing (copayment or deductible) may apply to these services.You have the right to withdraw your consent at any time, and such withdrawal will not affect your ability to receive care from your providers.
- **Mental Health Consent:** We have a behavioral health integration ("BHI") program designed to support patients experiencing challenges with their mental health. A behavioral health care manager and consulting psychiatrist works collaboratively with our physicians to help patients learn coping skills and make recommendations about medications if they might be useful. Your participation in the program is entirely voluntary. You have the right to withdraw your consent at any time, and such withdrawal will not affect your ability to receive care from your providers. Cost sharing (such as copayments, deductibles and co-insurance) may apply to both face-to-face and

non-face-to-face services provided, even if cost sharing is covered by supplemental insurers.By signing this form, you acknowledge that you understand the nature of BHI and provide your consent to participate and for your health information to be shared among your care team.

- **Remote Patient Monitoring (RPM) Consent:** We offer Remote Patient Monitoring ("RPM") services to help manage your chronic condition between office visits. RPM involves the regular collection and transmission of your health data (such as weight, blood pressure, blood glucose, or oxygen levels) from a device in your home to your care team. These readings are monitored daily, and your provider or a member of your care team may contact you if results fall outside of a set range or to support your treatment goals. RPM can improve early intervention, reduce hospitalizations, and help maintain your quality of life. Should you choose to receive RPM services, your provider agrees to only bill your insurance once per 30-day billing cycle. Standard Medicare Part B cost-sharing (copayment or deductible) may apply.
- **AI Scribing in the Office:** To support accurate documentation and help your provider focus more on you, our office may utilize a secure, HIPAA-compliant AI technology to assist with medical notes. A temporary recording and transcript of your visit are used to generate a draft, which your provider reviews and edits. Transcripts are stored securely for a limited time. Your privacy remains a top priority at every step.

Should you have questions about this consent please ask one of our staff or contact us at 314-842-7301

I have read this form, I understand what it says, and any questions of mine have been answered. I am signing this form voluntarily.

Print Patient Name _____

Patient Signature:_____ Date:_____