INFORMED CONSENT FOR TRANSITIONAL CARE MANAGEMENT SERVICES

You have engaged Quantum Physicians Group to provide transitional care management services upon your discharge from an inpatient setting. Physicians and other qualified health care practitioners will provide you with health care services and oversight to assist your transition back to a community setting in an effort to prevent or reduce readmissions and maintain continuity of care. Through face-to-face appointments as well as through remote means, you will receive health care services which may include, but are not limited to: medical assessment and examinations, review of discharge information and monitoring of on-going tests and treatments needed, inter-facing with other health care professionals who may assume care of your specific problems on a prospective basis, and education and connection to community resources.

Benefits. Transitional care management services provide a convenient way to maintain continuity of care and medical oversight while you are integrating back into your home and community life after discharge from an in-patient health care setting. Benefits to these services may include, but are not limited to: reducing or eliminating any gap in health care oversight during your transition back into the community setting; reducing the risk of readmission; saving time by eliminating the need to travel to in-person visits; increasing rehabilitation and healing potential after discharge; reducing exposure to others who may be sick; and connection with community resources that can assist your needs on an on-going basis.

Risks. Transitional care management services are meant to be short-term and do not substitute for ongoing care for chronic conditions. The biggest risk to receiving transitional care management services is that the providers are not available to provide 24-hour emergency response. Should you experience a sudden change in condition, you should call emergency first responders.

To the extent the services are conducted via a telehealth platform or otherwise virtual or remote setting, additional risks may apply. Potential risks of telehealth include, but are not limited to: the provider's inability to conduct a hands-on physical examination of you and your condition; delays in evaluation and treatment due to technical difficulties or interruptions; unauthorized access to your information; and loss of information due to technical failures.

Alternatives. You may choose alternatives to these transitional care management services. Alternatives are to forego receiving any transitional health care oversight and to find an alternative provider of health care services as needed. Both of these alternatives have the potential to create a gap in addressing your health care needs and may result in a decline in your condition requiring a re-admission.

NO GUARANTEES. I understand that receipt of medical services is not an exact science; therefore, no guarantees have been made to me as to the result of these services. I further understand that the transitional care management services are not meant to be a substitute for 24-hour supervision or emergency services and that I may experience a change in condition requiring immediate medical attention when not actively receiving services. I further understand that to fully benefit from these services, I must maintain regular communication with my care team and treating provider(s) and provide them with complete and accurate information. My active participation in this way is necessary to receiving proper care and oversight.

By signing below:

- I agree and consent to receive transitional care management services.
- I understand these services do not guarantee a result or a cure to my condition.
- I have been given the opportunity to ask questions I may have about: alternate forms of treatment, risks of non-treatment, steps that will occur during my treatment, and risks and hazards involved in the services.
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me.
- I have read this form or had it read to me.
- I understand the information in this form.
- I represent and warrant that I have the legal authority and legal capacity to sign this consent.
- I understand that I may withdraw my consent at any time.

Patient / Other Legally Authorized Representative (signature required) :

_____ _____

Print Name Signature

_____ _____

Date Time

Witness :

_____ _____

Print Name Signature

_____

Address (Street or P.O. Box)

_____

City, State, Zip