

## PATIENT CONSENT FORM FOR SCRIBE SERVICES

I understand my physician uses a professional medical scribe service that assists him in documentation. The scribe service may be remote.

I understand that this allows a more focused patient-physician engagement.

I understand that I do not have to pay for this service.

I understand that the medical scribes follow a professional code of ethics that ensures that all medical information discussed with my physician, or the staff will be kept confidential.

I agree to the use of a professional medical scribe when I discuss my healthcare issues with my physician.

<input type="checkbox"/> MAXIM MORADIAN, M.D.	<input type="checkbox"/> REVIK VARTANIAN, D.O.	<input type="checkbox"/> JAMES J. LIEU, D.O.
<b>PHYSICIAN</b>	<b>DATE OF SERVICE</b>	
<b>PRINTED NAME OF PATIENT OR AUTHORIZED REPRESENTATIVE</b>	<b>SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE</b>	<b>DATE SIGNED</b>