Tel: 443-858-9401 MedicineAtHome.NET Fax: 240-766-8060

2020 UNIVERSAL CONSENT FOR NEW PATIENTS

PATIENT NAME: ________________________________DOB: _____________ DATE: _________

CONSENT TO TREAT

I hereby authorize and consent to the performance of the physical examination and treatment by a physician, physician assistant or nurse practitioner from *Medicine at Home*. I understand that this consent is given in advance. This may also include orders for home visits for: nursing, physical therapies, occupational therapies, blood draws, urinalysis, x-rays, ultrasounds, EKGs, echocardiograms and cerumen decompaction. I understand that Medicine at Home is not a 24-hour emergency service and has no guaranteed availability for emergencies. I understand that in the event of an emergency or urgent medical condition I, or my representative, must dial 911. Under no circumstances should I postpone the care or evaluation of an urgent or emergency condition waiting for a visit or return communication (phone call, e-mail, or fax) from providers at Medicine at Home.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of *Medicine at Home* Notice of Privacy Practices (NPP). I understand that the NPP provides information about how protected health information about me and may be used and disclosed in providing care to me and receiving payment for that car. I understand that the terms of the notice may change as allowed by law.
Lastly, I understand that I can review the NNP at www.MedicineAtHome.NET.

HEALTH INSURANCE ACKNOWLEDGMENT

I request that the payment of authorized Medicare/Insurance carrier benefits be made on my behalf to *Medicine at Home* for any services furnished to me by that physician or supplier. I authorized any holder of medical information about me to release to the Centers of Medicare/Medicaid Services and its agent and/or other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services.

I understand that I am totally responsible for payment of my account unless *Medicine at Home* has previously arranged by contractual agreement to accept payment in full services (less copays, deductibles, co-insurance and/or non-covered services). I accept financial responsibility for all changes billed and the undersigned (jointly and severally) guarantee to pay all such charged. All bills are payable and become due on presentation. I agree if a payment of bills rendered is not made, and collection efforts are required, I hereby agree to pay and bills rendered to me together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due.

_________ **I acknowledge that I have read and understand this form, that I have been given the opportunity to ask questions and that I have no remaining questions at this time.**

____	______________________________
Signature of Patient / Legal Representative	Date
____	______________________________
Name of Legal Representative	Relationship to Patient