Patient Consent/Acknowledgement

Hello In There In-Home Primary Care
P. O. Box 1658
Biddeford, ME 04005
Ph. 207-358-3310 Fax 207-370-6045
Jodie Tompkins, NP
Kristina Laroche, Office Manager

PATIENT NAME:

DATE OF BIRTH:

CONSENT TO ASSESSMENT and RIGHTS AND RESPONSIBILITIES:

I/we voluntarily consent to such care encompassing medical assessment, treatment and diagnostic procedures provided by Hello In There In Home Primary Care and its associated providers, clinicians, and other personnel as is necessary in his/her professional judgment. I/we understand the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

RELEASE OF MEDICAL RECORDS:

I consent to release my hospital records and provider records to Hello In There In Home Primary Care. I understand that Hello In There In Home Primary Care will maintain a confidential medical record containing information about me and my medical condition. I authorize Hello In There In Home Primary Care to release copies of my medical records as necessary to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment, and for quality assurance, survey and accreditation purposes.

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:

I assign Hello In There In Home Primary Care any medical insurance benefits payable to me for services provided by Hello In There In Home Primary Care and permit Hello In There In Home Primary Care to submit a claim for payment to Medicare or Medicaid or to other third party payers and/or any appropriate intermediary agency necessary, to bill for services provider by Hello In There In Home Primary Care. I choose Hello In There In Home Primary Care to act as my representative in claim denial appeals. Subject to applicable laws and the terms and conditions of any applicable contract between Hello In There In Home Primary Care and a third-party pay or, I understand I am responsible for fees not reimbursed by my health insurance including, but not limited to, deductibles and/or co-payments.

MEDICARE/MEDICAID PAYMENT AUTHORIZATION COVERAGE:

As a Medicare or Medicaid patient, I certify that the information I have provided in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. If Hello In There In Home Primary Care believes I no longer qualify for benefits under Title XVIII and/or Title XIX of the Social Security Act, I will be notified verbally and in writing of any potentiometer payment liability.

PRESCRIPTIONS:

Hello In There In Home Primary Care uses our system to send prescriptions electronically. Please let us know if you have any questions about this.

AFTER HOURS CALLS:

If there is an emergency please dial 911. If it is not an emergency, please leave a voicemail for a call back during regular business hours. If you have any questions, please let us know.

NOTICE OF PRIVACY:

I acknowledge that I have received the Hello In There In Home Primary Care Notice of Privacy Practices. I understand that the Notice of Privacy Practices explains how Hello In There In Home Primary Care may use and disclose confidential health information that identified me. I consent to let Hello In There In Home Primary Care use and disclose health information about me as described in the Notice of Privacy Practices. In doing so I am consenting to the use and disclosure of health information about substance abuse, psychiatric care, or HIV, if applicable. I consent to the release of health information about me to my insurer, other third party payors, and any agents or consultants that help Hello In There In Home Primary Care get paid or assist in my treatment or its health care operations. I can revoke my consent in writing at any time except to the extent that Hello In There In Home Primary Care has already relied on my consent.

I have read this form and understand its contents at this date:

Patient or responsible party signature_____

Date:

Relationship to patient:

Reason patient is unable to sign:

Witness Signature:_____

Date: