PHYSICIAN
HOUSECALLS

CONSENT FOR TREATMENT

Patient Name: ___________________________________ **DOB _____________________**

I hereby voluntarily consent to the rendering of healthcare services by providers of Physician Housecalls I acknowledge and understand that this consent authorizes providers of Physician Housecalls to manage and treat medical conditions, including but not limited to, physical examinations, diagnostic procedures, performance of tests, and administration of medications and therapies. I understand that I have the right to discuss proposed procedures or treatments with my provider and to consent to, or refuse such procedures or treatments. I understand that there are limitations to my care in the setting that I reside, and there are no guarantees to the effect of such examination or treatment of my condition. I understand that this consent will be valid and remain in effect if I am in the care of Physician Housecalls.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Physician Housecalls to release information from my medical record for treatment, payment and healthcare operations as described in the Physician Housecalls Notice of Privacy Practices to insurance companies, third party payers, or authorized agents; or claims review organizations to process a claim for payment on my behalf. This information may be available to any and all employer's insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time except to the extent that action has already been taken in reliance on it.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Physician Housecalls all of my rights, title and interest to medical reimbursement benefits under my insurance policy (s). If my insurance benefits are provided through and ERISA (Employment Retirement Income Security Act) plan, I hereby assign, transfer, and set over my rights, title, and interest as beneficiary of the ERISA plan to Physician Housecalls regarding my treatment and care. I also assign Physician Housecalls all claims and causes of action of any kind whatsoever against an insurance company or other third-party payer or against any other person or entity for payment or reimbursement for services, goods, or facilities provided by Physician Housecalls. I understand that this assignment is given to Physician Housecalls to pursue these claims on my behalf as a courtesy to me and that Physician Housecalls is not required to exercise these rights and may do so in its sole discretion without any liability for its decision. I also agree that this assignment does not in any way affect my obligation to pay Physician Housecalls charges.

MEDICARE AND MEDICAID

I hereby certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct. I authorize release of information needed to act on this request. I request that payment of physician/provider Medicare and Medicaid benefits, if applicable, be made on my behalf.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I hereby acknowledge that I have received or have been presented with the opportunity to receive the Physician Housecalls Financial Policy. I understand and agree to the policy. I understand that if there is no guarantee of reimbursement or payment from any insurance company or other payer and that I am financially responsible for all charges not paid for any reason, including but not limited to charges that are non-covered, no billed, not collected, or otherwise not paid by insurance companies or third-party payers. I understand that all deductibles and co-payments will be due by me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that Physician Housecalls has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

AUTHORIZATION FOR COMMUNICATION

I hereby authorize Physician Housecalls providers, employees, and representatives to communicate with myself, designated person(s) below, other health care providers, and persons involved in my healthcare/business operations, using secure methods of communication.

I hereby consent to the following person (s) to be personal representatives to receive or know personal information regarding my medical status and plan of care. I understand that this information will be effective at the date of signature and will remain in effect until Physician Housecalls is notified in writing of requested change.

____ ____

Name Relationship Name Relationship

I understand and agree to the above statements in this document

____

Date Name Relationship

PHI USE AND DISCLOSURE AUTHORIZATION

I authorize______________________________________ (name of provider to send records) to use and disclose the following protected health information (PHI):

____ All Records (including records pertaining to mental health, communicable diseases, HIV or AIDS, genetic markers, and treatment of drug and alcohol abuse) ___ Lab Tests ___ Radiology ___ EKG ___ Nuclear Tests ___ ED Records ___ Hospital Records ___ Operative Reports ____ Pathology Reports ___ Diagnostic Tests ___ Medical Notes ___ All Records from dates _________ to ________.

___ I hereby authorize the release of my complete health record with the exception of the following information:

___ Mental Health Records

___ Communicable diseases (including HIV and AIDS)

___ Alcohol/drug abuse treatment

___ Genetic markers

___ Other (please specify) ____

Purpose of Disclosure: ☐At request of patient ☐Continuing Care ☐Personal Records ☐Legal ☐Insurance ☐Other Name of Entity or Person(s) to Receive Info:

Physician Housecalls

304 S 29th St

Chickasha, OK 73018

Fax: (855) 223-1999

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to addresses above. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that this authorization is effective 12 months from signature date unless a different expiration date is provided.

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

____

Name of Patient or Personal Representative (Type/Print)

____ ______________________________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority

PHYSICIAN
HOUSECALLS

Patient Drug Contract

This drug contract stipulates the conditions under which Physician Housecalls will provide controlled medications to patients. The stipulations are as follows:

- If any medications are lost, stolen or otherwise unavailable, no more medications will be prescribed until the next available refill date.
- Patient will submit to routine drug screens upon request, and if the tests are positive for any controlled substances other than those that are prescribed by the attending provider, no other medications will be provided, and services may be terminated.
- Patient agrees to reserve the medications only for personal use to control pain and will be truthful in reports of pain ratings.
- Any positive drug test for any illegal substance may result in immediate termination of services.
- Any negative drug tests for prescribed controlled substances may result in immediate termination of services.
- Patient agrees to receive controlled medication prescriptions only from Physician Housecalls providers. If the Prescription Monitoring Program reveals prescriptions from other providers, the patient may be terminated from Physician Housecalls practice.
- Physician Housecalls reserves the right to not prescribe or stop prescribing controlled substances if use is deemed inappropriate, outside of our scope, or should a violation of this contract occur.
- We may continue to manage medical conditions without the management of chronic pain, alongside the care of an outside chronic pain manager.

I hereby agree to the conditions listed above and understand that Physician Housecalls will not provide medications to me if the conditions are not met. With my signature, I acknowledge that the opioid patient information sheet has been made available.

____ ________________________

Patient Signature Date

____ ________________________

Physician Housecalls Representative Signature Date