RETURN

DISCLOSURE TO FAMILES AND LOVED ONES (EMERGENCY CONTACTS)

I authorize Primary Care House Calls, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and /or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Primary Care House Calls to disclose my personal health information to the following people.

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the legally authorized representative for whom I am signing and understand that no guarantee or assurance has been made as to the results for which may be obtained.

_____

Patient or Authorized Representative Initials

PHOTO DOCUMENTATION

I hereby grant authorization for Primary Care House Calls, Medical House Calls to make a copy of my photo identification to be included in my confidential record as well as to take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

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Patient or Authorized Representative Initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Primary Care House Calls, Privacy Practices and agree with these policies.

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Patient or Authorized Representative Initials

INSURANCE ASSIGNEMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Primary Care House Calls, to release any medical information required during examination and treatment to my insurance, and I permit payment to Primary Care House Calls, from my insurance company for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such a labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Primary Care House Calls providers.

_____ _____

Date Signature of Patient or Authorized Representative

Primary Care House Calls, 2744 Gulf Breeze Parkway, Gulf Breeze, FL 32563

Phone 850-934-5713 Fax 850-934-0379