Patient Consent to Treat

CROSSROADS FAMILY MEDICINE AND PEDIATRICS

194A Pleasant Street, Suite 101 • Concord, NH 03301 • (603) 856-8828 Fax: (603) 856-8813

Patient Name: ____ **DOB**: ____________ **Sex:** M / F **GI:**________ **SO:**_______

Mailing Address: ____
(street) (town) (zip code)

Home Phone:________________________ **Cell**:_________________________ **How would you like reminder calls**: HOME / CELL

Email:____ **Would you like to have access to our Patient Portal?** YES / NO

Name of Parent(s)/Legal Guardian: ____________________________ Relationship to patient:______________DOB:___________
(if under the age of 18)
____________________________ Relationship to patient:______________DOB:___________

Primary Insurance Policy Subscriber Name:____ **DOB**: ____________________

Insurance Policy Subscriber Address (if different than above):____

AUTHORIZATION FOR TREATMENT
I authorize the Provider(s) or his/her designee(s) in charge of the patient's care to administer treatment as deemed necessary or advisable in the diagnosis and treatment of any conditions related to the patient. I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person, or one year following date of signature.

ASSIGNMENT OF BENEFITS and PAYMENT TERMS
I agree to assign to Crossroads Family Medicine, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Crossroads Family Medicine in accordance with its regular rates and terms for all services rendered. All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide Crossroads Family Medicine with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

ELECTRONIC MEDICAL RECORDS ACKNOWLEDGEMENT
Crossroads Family Medicine primarily utilizes an electronic medical record (EMR) to capture medical information. This system allows pertinent medical information to be available to healthcare providers, including primary care providers, providers that provide on-call services, consultants, Emergency Department medical staff, as well as other specialist related to services being provided. Crossroads Family Medicine is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Crossroads Family Medicine Notice of Privacy Practices, available to me upon request.

I have read and fully understand the information above. I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions on behalf of the patient.

VERBAL AUTHORIZATION TO DISCUSS MY HEALTH AND MEDICAL INFORMATION
If I am not present and need Crossroads Family Medicine health care providers and staff to verbally release or discuss health and medical information, I authorize to the following:

Name:______________________________________ Relationship:______________ Phone:______________________

Name:______________________________________ Relationship:______________ Phone:______________________

I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person, or one year following date of signature.
I understand that I can revoke, update, or change this verbal authorization at any time in writing. The termination to verbally release health and medical information is effective on the date the physician office receives it. It does not apply to any information released prior to the date of receipt of the writing termination.

Signature: ____ **Date:** ______________________

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Crossroads Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Crossroads Family Medicine describes such uses and disclosures more completely in our HIPAA Patient Manual, which is available upon request.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Crossroads Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Crossroads Family Medicine.

With this consent, Crossroads Family Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Crossroads Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, Crossroads Family Medicine may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that Crossroads Family Medicine restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Crossroads Family Medicine to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Crossroads Family Medicine may decline to provide treatment to me.

________________________________ _______________ __________________
Signature of Patient or Legal Guardian | Date | Relation to Patient

________________________________ ____________________________________
Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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Patient: ____
(First Name) (Middle Initial) (Last Name)

Mailing Address: ____
(street) (town) (zip code)

Date of Birth: ____________________________

CROSSROADS FAMILY MEDICINE is authorized to ☐**RECEIVE** ☐**DISCLOSE** medical records from/to the following source:

Facility: ____ Provider: ____

Mailing Address: ____

City: _______________________________ State: ________ Zip: _____________ Phone: ________________________

For the following purpose: ☐ Provider Transfer ☐ Continuation of care ☐ Other _________________________________

1. **I GIVE PERMISSION TO RELEASE:**

☐ ALL MEDICAL RECORDS

☐ MEDICAL RECORDS WITH DATES OF SERVICE FROM ____________________ TO ____________________.

☐ ONLY THE FOLLOWING MEDICAL RECORDS: ____

INCLUDE SENSITIVE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE AND/OR HIV/AIDS?

YES, DISCLOSE ALL SENSITIVE INFORMATION: ____
Signature of Patient/Guardian Signature/Legal Representative

☐ **NO, DO NOT** DISCLOSE SENSITIVE INFORMATION.

2. I release Crossroads Family Medicine and Pediatrics, and the source listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization.
3. I understand I have the right to revoke this authorization at any time (with certain exceptions) by submitting a written statement to Crossroads Family Medicine and Pediatrics, and to the extent that information has already been disclosed/received in reliance on this authorization
4. I understand health care providers generally may not condition treatment on the provision of this authorization.
5. I understand the information disclosed per this authorization may be subject to redisclosure and no longer be protected.

This Authorization expires on _____/_____/20_____, *OR, if not indicated, 90 days from the date signed.*

____ ______________________________
Signature of Patient/Guardian Signature/Legal Representative Date

____
If not patient's signature, description of signer's Authority to Act

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Name of patient: ____ **DOB**: __________________________

Legal Guardians:

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

Authorized Caregivers:

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

Name: ____ Relationship: ______________________________

By signing this form, I am hereby giving Crossroads Family Medicine permission to treat the patient named above in my absence if the patient is accompanied by any one of the guardians or caregivers named above.

____ ____________________________________

Signature of Guardian Date

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To avoid conflicts, please carefully review the notifications below and initial:

________ **Co-pays and balances due (based on claim processing) are due prior to every visit. Failure to pay co-pays and balances due will result in cancellation of your visit.**

________ **Do not miss your scheduled appointments or reschedule your appointments within 24 hours of the appointment time. Multiple missed or short-notice rescheduled appointments may result in being discharged from the practice.**

________ **Medications will not be refilled between appointments. Patients should not rely on pharmacies to notify this clinic of needed refills (the information provided by pharmacies is often incorrect and therefore unreliable). Patients will be prescribed enough of each medication to last until their next scheduled appointment. Appointments will be pre-scheduled to avoid problems with patients unexpectedly running out of medications. Patients should not miss scheduled appointments or move appointments beyond the refill period of their medications. It is the patient's responsibility to inform their provider at the time of any visit that they will be running out of medications and to insure their next visit is scheduled prior to any needed refill date.**

________ **Most commercial insurance companies allow a preventative medicine (often referred to as an annual physical) visit on an annual basis, however please understand that Crossroads Family Medicine does not guarantee a patient's insurance company will cover all or any of the fees associated with this visit. Also keep in mind, that although many insurance companies may waive standard co-pays for this type of visit, if additional acute or chronic diagnoses and/or treatment options (including referrals and medication refills) are discussed, additional fees and any associated standard co-pay will be applied to this portion of the visit. If a patient has questions about claim processing, they must address these concerns with their provider in advance of the visit in question. Any questions that arise following claim processing should be discussed with Dr. Loeser.**

________ **The providers and staff at Crossroads Family Medicine will do their best to offer quality care to all patients. We will work hard to avoid problems and conflicts, and to resolve them in a timely manner should they occur. However, if at any time a patient or representative of a patient treats a member of the Crossroads Family Medicine team in an inappropriate manner, they may be discharged from this practice with a mandatory 30-day notice. Conversely, if any patient feels they are not being treated fairly or are unhappy with their care, they should discuss these concerns immediately with Dr. Loeser.**

By signing this notification, you acknowledge you have read and understand the information provided.

____ ______________________________

Signature of Patient/Guardian Date

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