Advanced Medical Care
Home Visits

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent and authorize Selam Estefanos, ARNP, and Advanced Medical Care to the perform evaluations, diagnostic procedures, testing, and treatment. I understand that I may have some of these services provided under the direction of Selam Estefanos, ARNP or by third-party providers. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

2. Consent to Release Information

I acknowledge that Selam Estefanos, ARNP, and Advanced Medical Care may release my protected health information as necessary for treatment, payment, and health care operations, and I acknowledge that a Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Selam Estefanos, ARNP, and Advanced Medical Care. I acknowledge and consent to allow Selam Estefanos, ARNP, and Advanced Medical Care to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Selam Estefanos, ARNP, and Advanced Medical Care all rights, title and interest in payments from third party payors including Medicare. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit.

Initial HERE:

→_____**Failure to provide complete insurance information may result in patient responsibility for the entire bill**.

→_____**If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately** I understand and agree that I will be responsible for any deductible, co-pay or balance due that Selam Estefanos, ARNP, and Advanced Medical Care are unable to collect from my third- party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys'or collection agencies, or lawsuit filed, I agree to pay all patient charges and reasonable attorney's fees.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I further consent to participation in the Chronic Care Management Service through Medicare if applicable. I request that payment or authorized benefits be made to Selam Estefanos, ARNP, and Advanced Medical Care on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Selam Estefanos, ARNP, and Advanced Medical Care. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Selam Estefanos, ARNP, and Advanced Medical Care will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

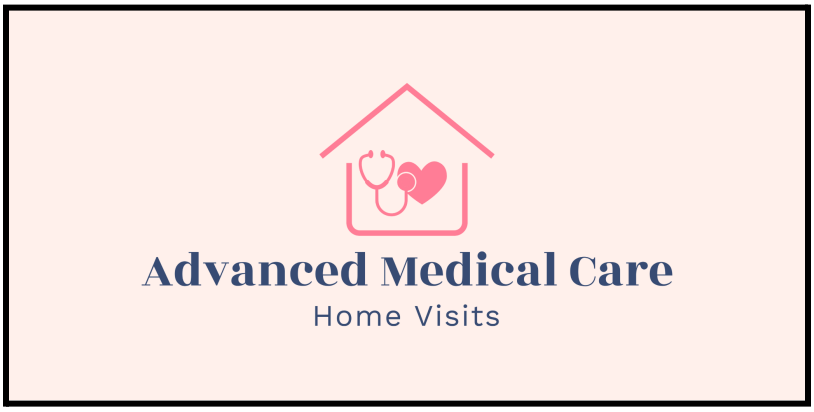
I understand that and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

I ACKNOWLEDGE ALL 7 points above.

Name of Patient, Printed:_____

Signature of Patient or Authorized Representative:_____

Date:_____



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

Date of Birth_____SSN:_____

FORMER PHYSICIAN'S INFO:

Name:_____

Address:_____

City/State/ZIP:_____

INFORMATION TO BE SENT TO: **Advanced Medical Care, Selam Estefanos, ARNP**

INFORMATION TO BE RELEASED (please check one):

___ The most recent 2 years of pertinent information (chart notes, labs, X-rays)

___ All medical records

___ Other (please specify)_____

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature of Patient or Authorized Representative:_____

Date:_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Advanced Medical Care is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your healthcare information to other healthcare professionals within or outside of our practice for the purpose of treatment, payment or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Worker's Compensation

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health and Safety

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Your Health Information Rights
• You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Advanced Medical Care is not required to agree to the restriction that you requested.

• You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

• You have the right to inspect and copy your health information.

• You have a right to request that Advanced Medical Care amend your protected health information. Please be advised, however, that Advanced Medical Care is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

• You have the right to receive an accounting of disclosures of your protected health information made by Advanced Medical Care.

• You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide Advanced Medical Care and Selam Estefanos, ARNP, with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

Patient's Name (print)_____
Patient's Signature_____Date_____
Or Authorized Representative Signature_____Date_____