Mary Snellngs MD
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I, _____ (printed name), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent remain in force from this time forward. In addition to the above, a condition of being admitted for treatment as a patient of **Doctors At Home**, I acknowledge the following **Consent of Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits, Medicare/Medicaid.**

Assignment of Benefit, Frequency Rights/Hotline Procedure, and **Additional Understandings.**

I understand by acknowledging this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and possibly termination of services from my doctor and his or her practice.

Conditions of Admittance

As a condition of being admitted for treatment as an outpatient of the **Doctors At Home**, I agree to the following:

1. Consent of Treatment: I voluntarily consent and request to treatment, I authorize the treating physician(s) and their assistants to perform medical treatment and technical procedures, to administer drugs, and to render care as their judgment may indicate to be necessary or advisable. I understand that the services provided to me, are provided by doctors or physicians assistants or nurse practitioners. **Doctors At Home** will maintain a record of the care and services you receive. This consent only covers your protected health information created while you are a patient of **Doctors At Home**. Your protected health information pertains to your diagnosis and or treatment, including but not limited to information concerning medical illness (except for psychotherapy notes), use of alcohol or drugs or *communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"),* laboratory test results, medical history, treatment history, treatment progress or any other such related information. By signing this form, you consent that **Doctors At Home** may use and/or disclosure of pre-existing health information about you for treatment, payment, healthcare operations and as otherwise allowed by law, our *Notice of Health Information Practice* provides information about how **Doctors At Home**, its physicians, and its medical staff may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. Consent for any major surgical procedures or other procedures by physicians/surgeons requiring additional consent will be requested by the physician performing such, and shall be obtained preceding the procedure with exception for those procedures considered necessary for extreme, life-saving emergencies.

2. Authorization to Release Medical Information: I authorize **Doctors At Home** and any treating physician to furnish requested information from patient medical and other records to:

a) Any insurance company or third party payer for the purpose of payment to **Doctors At Home** or a treating medical provider.
b) Any other persons or entities financially responsible for the patient's treatment.
c) Representative of governmental agencies in accordance with law. Such information may include, but not be limited to, information about communicable diseases such as AIDS, or HIV. I authorize release of information from or the review of the patient records for medical audit, utilization reviews, or quality assurance reviews. I authorize **Doctors At Home** to release information from our copies of the patient medical records to the referring physician or to a skilled nursing facility or health care facility which I may be transferred.
d) Only the designated person, _____ (name/number) authorized to read or have access to or be included in patient care conference or discussers on my behalf. I understand that this document does not supersede traditional power of attorney, yet it is my intent that only the person(s) listed are hereby granted access to my records.

I authorize the release of the following information (check all that apply)

All Records	Consultation Assessment
Treatment plan	Medications
Lab Results	History and Physical
Billing Records	Radiology Results
Discharge Summary	

This information is necessary for the following purposes (check all that apply)

Follow up Care	Disability Benefits
Insurance	Attorney/Legal
Transfer of Care	Other (Please Explain): _____

I give my special permission to release my information regarding items listed below:
INITIALS:
HIV Medical Info Psychiatric Information Substance Abuse

3. Assignment of Insurance Benefits: I assign to **Doctors At Home** all rights to file claims and collect payment for services provided. I further assign all rights to payments for physician services under said policies to Doctors At Home physicians and/or other providers, which provide treatment for me while I am a patient. I understand I am responsible for providing all insurance information available at the time of admission and periodically for verification. I agree to pay any amounts due to **Doctors At Home** that is not covered by insurance including co-pays and/or annual deductibles as required by my insurance. **I understand I'm required to submit payment upon receipt, to Doctors At Home for any co-pays, deductibles or other required out of pocket expenses**.
***I am responsible to inform **Doctors At Home** if I change my payer source/insurance to a HMO, Medicare Advantage Plan or other health plan: Without proper notification, I understand I may be liable for payment of the Medical Services rendered by Doctors At Home.

4. Medicare/Medicaid Assignment of Benefit: I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that the payment of authorized benefit be made on my behalf to **Doctors At Home**. I assign benefits payable for services to the organization submitting a claim on my behalf.
Medicaid: I understand that Medicaid recipients are responsible for payment for any medical services received that are beyond the scope of the Texas Medical Program, as determined by the Texas Department of Health and Human Services. All such payments are due and payable at the time of discharge.

5. Frequency Rights/Hotline Procedure: I have received an explanation of my Patient Bill of Rights of the Elderly, as appropriate. I have been notified of my rights to voice a complaint and may direct that complaint with the Secretary of the Health and Human Service. (US Department of Health and Human Services at 200 Independence Ave, SW. Washington D.C. 20201) I may also direct a complaint to **Doctors At Home** to do the investigation of the complaint, which will be initiated within 10 calendar days and resolved within 30-calendar day's receipt. I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any abuse, neglect and exploitation agency testing policy and hazardous waste disposal in home. I have been advised verbally and in writing the purpose and my right pertaining to the collection of information and the Privacy Act. HIPPA—I have received the Notice of Privacy Practices and consent to the agency's use and/or disclosure of protected health information for the patient.

6. Attestion:
A) I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me with respect to the result of any examination or treatment to be performed.
B) I authorize Doctors At Home to use its discretion to retain or dispose of any tissue removed during treatment.
C) **My signature below attests that I choose Dr. Mary Snellings as my PCP (Primary Care Physician).**

Complete all areas below: (please provide copies of Medicare and Secondary Insurance cards)

Patient Name (printed)	Patient Signature Date
Name of POA	Phone Number
Guarantor (Person responsible for co-payments/deductible)	Mailing Address
Guarantor Phone Number	Guarantor Email Address