HOMECARE MEDICINE *of* ATLANTA

PATIENT CONSENT / ACKNOWLEDGEMENT

PATIENT NAME:

CONSENT TO ASSESSMENT and RIGHTS AND RESPONSIBILITIES:
I/we voluntarily consent to such care encompassing medical assessment, treatment and diagnostic procedures provided by HomeCare Medicine of Atlanta (HCMA) and its associated physicians, clinicians, and other personnel as is necessary in his/her professional judgment. I/we understand the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

RELEASE OF MEDICAL RECORDS:
I consent to release my hospital records and physician records to HCMA. I understand that HCMA will maintain a confidential medical record containing information about my medical condition and me. I authorize HCMA to release copies of my medical records, as necessary, to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment, and for quality assurance, survey and accreditation purposes.

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:
I assign to HCMA any medical insurance benefits payable to me for services provided by HCMA and permit HCMA to submit a claim for payment to Medicare or Medicaid or to other third party payers and/or any appropriate intermediary agencies as necessary, to bill for services provided by HCMA. I choose HCMA to act as my representative in claim denial appeals. Subject to applicable laws and the terms and conditions of any applicable contract between HCMA and a third-party payer, I understand that I am responsible for fees not reimbursed by my health insurance including, but not limited to, deductibles and/or co-payments.

MEDICARE/MEDICAID PAYMENT AUTHORIZATION COVERAGE:
As a Medicare or Medicaid patient, I certify that the information I have provided in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. If HCMA believes that I no longer qualify for benefits under Title XVIII and/or Title XIX of the Social Security Act, I will be notified verbally and in writing of any potential payment liability.

3330 Cumberland Blvd.
Ste 500
Atlanta, GA 30339
www.hcmatl.com

1.800.609.7494 Office
1.770.740.2611 Local
1.770.800.3100 Fax
info@hcmatl.com

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NOTICE OF PRIVACY:

I acknowledge that I have received the HCMA Notice of Privacy Practices. I understand that the Notice of Privacy Practices explains how HCMA may use and disclose confidential health information that identifies me. I consent to let HCMA use and disclose health information about me as described in the Notice of Privacy Practices. In doing so, I am consenting to the use and disclosure of health information about substance abuse, psychiatric care, or HIV, if applicable. I consent to the release of health information about me to my insurer, other third party payers, and any agents or consultants that help HCMA get paid or assist in my treatment or its health care operations. I can revoke my consent in writing at any time except to the extent that HCMA has already relied on my consent.

I have read this form and understand its contents at this date.

Patient or responsible party signature: _____

Date: _____

Relationship to Patient: _____

Phone number: _____

Email Address: _____

Reason Patient is unable to sign (if applicable): _____

Witness signature: _____

Date: _____

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