CHARIS PHYSICIANS HOUSECALLS PLLC
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CONSENT FORM

1. **Consent to Treatment:**

I consent to the care of Charis Physicians Housecalls, PLLC and to procedures required in my medical care, which may include but not limited to routine diagnostic procedure and such medical treatment as named attending physician/s, his/her assistants or his/her designees (physician associates) which the physician considers to be necessary. I understand that the practice of medicine is NOT an exact science and that diagnosis and treatment may involve risks of injury or death. I acknowledge that no guarantees have been, or can be made, to me as the result of treatments or examination/s.

2. **Financial Agreement:**

In consideration of the medical services to be provided by my assigned physician, I hereby promise to pay for the care I received from Charis Physicians Housecalls, PLLC effective on the date that I signed this agreement.
As a courtesy to you, Charis Physicians Housecalls, PLLC will bill your insurance company. You agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You agree to pay any services that are not covered by your insurance company. This includes, but not limited to, coinsurance, deductibles, not covered benefits due to policy limits or exclusions as well as failure to comply with your insurance plan requirements. You also agree that if Charis Physicians Housecalls, PLLC must initiate collection efforts to recover amounts owed by you, then in addition to amounts incurred for the services rendered you will pay (a) any and all costs incurred by Charis Physicians Housecalls, PLLC in pursuing collections, including, but not limited to reasonable attorney's fees, and (b) any court costs of litigations incurred by Charis Physicians Housecalls, PLLC that applicable rules or statutes permit our recovery.

3. **Assignment of Benefits:**

   In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage to pay Charis Physicians Housecalls, PLLC directly for the services rendered to me. I hereby irrevocably assign and transfer to Charis Physicians, PLLC all right, title and interests in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled services or I am entitled to recover.
   I also irrevocably assigned to Charis Physicians Housecalls, PLLC all right, title and interest in benefits payable out of any third party action against any other person, entity or insurance company or out of any recover under the uninsured motorist provisions or the medical payment provisions of any insurance policies under which the patient may be entitles as directly related to the medical care provided by my assigned physician/s.

4. **Medicare Patient Certification and Assignment of Benefit:**

   I certify that any information provided in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Charis Physicians Housecalls, PLLC by Medicare and/or Medicaid program.

5. **Patient Self Determination Act:**

   I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills) I have also been furnished with written information regarding patient rights and responsibilities and other information related to my care.

   Please initial or place a mark next to one of the following applicable statement:

   _____I executed and Advance Directive and have been requested to supply a copy to Charis Physicians Housecalls, PLLC

   _____I have not executed and Advance Directive, wish to execute one and have received information on how to execute an Advance Directive.

   _____I have not executed and Advance Directive and do not wish to do so at this time.

6. **Notice of Privacy Practices:**

   I acknowledge that I have received Notice of Privacy Practices, which describes the way in which Charis Physicians Housecalls, PLLC under HIPPA Privacy Act may use or disclose my healthcare information

   Acknowledge _____ (initial)

7. **Legal Relationships:**

Independent contractors such as: Labs, Portable X-Ray, EKG, DME companies etc. are responsible for their own actions and that Charis Physicians Housecalls, PLLC shall not be liable for the acts or omissions of any such contractors.

I, the undersigned as the patient of legal agent of the patient, hereby certify I have read, and fully understand this Conditions of Admissions and Authorization for Medical treatment, and that I have signed this Conditions of Admissions and Authorizations knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guaranteed from anyone as to the results that may be obtained by any medical treatment or services.

Patient Signature _____Date_____

Witness Signature _____Date_____

Authorized Representative Signature _____Date_____

Relationship of Patient_____Date_____

Witness Signature_____Date_____

Patient Name _____MR#_____

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