DocCare
MEDICAL CLINIC

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by DocCare Medical Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of DMC. I understand that diagnosis or treatment of me by DMC may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the DMC *Notice of Privacy Practices* prior to signing this document. The DMC *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy* Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of DMC. The *Notice of Privacy Practices* for DMC is also provided at Location Full Address. This *Notice of Privacy Practices* also describes my rights and duties of DMC with respect to my protected health information. DMC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by DMC.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from DMC asking for one at the time of next appointment.

Communication Authorizations

We may need to contact you for a number of reasons including provide information about your treatment or payment for your care. We may disclose your protected health information in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances (PHI). We may leave messages regarding refills, appointments, test results or other information we deem appropriate.
Please write the number(s) you would like us to use on the line below or, if you do not want us to leave messages, write "none" or leave blank:

We may use emails for communication. Sending your PHI by email carries risk. Most standard email does not provide a secure means of communication. There is a risk that PHI may be disclosed to, or accessed by, unauthorized individuals if unencrypted. Emails can be lost or miss delivered. If you do not receive a response to an email sent to Practice, please call or write instead. Please write the email address you would like us to share your PHI. If you do not want us to communicate by email, please write "none" or leave blank.

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Assignment of Benefits

I hereby assign, grant and transfer to DMC, now and in the future, all of my rights and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third party payer for those cots I incur in receiving services from DMC. The included insurance policies and insurer would include, but are not limited to, health, auto, UM and PIP; and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to DMC was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to DMC the amount due me in any potential or pending claim for medical benefits under the respective policies, expressly including all PIP policies. I agree that should the amount received DMC be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services by DMC is not covered by said insurance policy, I am responsible to DMC.

Financial Responsibility

This is an agreement between DocCare LLC DBA DMC, a Florida Corporation, as a creditor, and the Patient/ Debtor named on this form.

In this agreement the words “I”, “you”, “your”, and "yours" mean the Patient/Debtor. The word “account” means any account that has been established in your name to which charges are made and payments credited. The words “we”, “us,” and “our” refer to DMC and/or its affiliated entities.

Insurance: Insurance is a contract between you and your insurance company. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely shall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of DMC. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to ‘pay’ for care that is not covered, nor do we delete or change the content in the record that my prevent, or cause, it to be considered covered.

_____ Initials HMO Plans: Any co-payments required by an insurance company must be paid at the time of service.

_____ Initials PPO Plans: DMC has agreed to accept the discounted rate from your plan, and we will estimate balances to the best of ability. However, since these are estimates only, I understand that any remaining balances due to deductibles, co-insurance, and non-covered claims are my responsibility to pay DMC. Your appointment may be rescheduled if your estimated amount due is not paid at check in.

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_____ Initials Missed Appointment Fee: I understand that Appointment Reminders are a courtesy. Failure to show up for, or cancelation of an appointment with less than 24 hour notice, may result in a no show or same day cancellation fee assessed to my account. The no show or same day cancellation fee is $25.00. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from DMC.

_____ Initials Administrative charges: I understand that additional administrative charges may apply for items such as the completion of medical forms, telephone consultations, and physician letters. For copy of medical records, there is $1.00 per page for paper records for the first 25 pages and $0.25 for each page in excess of 25 pages and/or a $2.00 charge for non-paper record, plus any applicable postage. Please note that this office does not complete FMLA or disability forms: these forms will need to be filled out by your primary care provider.

Self-Pay Request

_____ Initials I want to be self-pay. I do not want my insurance company(ies) to receive health care information bout this treatment. I understand if I want to request restriction on release of my healthy information to my insurance company(ies), I have to complete Request to Restrict Use and Disclosure of Protected Information form. I understand I may be required to pay full amount due to DMC for my visit at the time of service.

Guarantee of Payment

For value received, including buy not limited to the service rendered, I agree to guarantee and promise to pay DMC all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writings, all charges shall be paid at discharge, time of visit or upon presentation of the first bill by DMC. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if DMC is required to bring a claim or file an action to enforce this agreement, DMC shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed DMC for its services. Based on permissible purpose under the Fair Credit Reporting Act, DMC reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.

Patient/Guarantor (Print): _____

Patient/Guarantor (Signature): _____ Date: _____