Florida Elder Care & Wellness
We Care About You

CLIENT CONSENT FOR RELEASE OF MEDICAL RECORDS

Date: _____

To:

_____

_____

_____

I _____ hereby request and authorize the release of my medical records to:

Florida Elder Care & Wellness, LLC

1200 Pinewood Street

Clewiston, FL 33440

Phone: (863) 228 6723

Fax: (833) 877 2291

Requested Information:

_____

_____

_____ _____

Signature of Patient/Person Giving Consent **Signature of Witness**

_____ _____

Print Name **Date of Birth**

Florida Elder Care & Wellness
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CONSENT TO TREAT

1. I_____ give permission for **Florida Elder Care & Wellness, LLC** to give me medical treatment.
2. I give permission to **Florida Elder Care & Wellness, LLC** to obtain information from pharmacies and medication vendors I use.
3. I allow **Florida Elder Care & Wellness, LLC** to file for insurance benefits to pay for the care I receive. I understand that:
    a. **Florida Elder Care & Wellness, LLC** may have to send my medical record information to my insurance company.
    b. I must pay my share of the costs.
    c. I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
4. I understand:
    a. I have the right to refuse any procedure or treatment.
    b. I have the right to discuss all medical treatments with my provider.

_____ _____

Patient's Signature **Date**

_____

Print Name

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PATIENT CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE MY CONSENT FOR **FLORIDA ELDER CARE & WELLNESS**, LLC TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. FLORIDA ELDER CARE & WELLNESS, LLC NOTIE OF PRIVACY PRACTICE PROVIDES A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURE.

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT.

FLORIDA ELDER CARE & WELLNESS, LLC RESERVES THE RIGHT TO REVISE THEIR NOTICE OF PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO

FLORIDA ELDER CARE & WELLNESS

1200 PINEWOOD STREET

CLEWISTON, FL 33440

WITH CONSENT, FLORIDA ELDER CARE & WELLNESS, LLC MAY CALL MY HOME OR OTHER ALTERNATIVE LOCATION AND LEAVE *A* MESSAGE ON VOICEMAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALLS PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS AMONG OTHERS.

WITH THIS CONSENT, FLORIDA ELDER CARE & WELLNESS, LLC MAY MAIL TO MY HOME OR OTHER ALTERNATIVE LOCATIONS ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS AS LONG AS THEY ARE MARKED PERSONAL AND CONFIDENTIAL.

WITH THIS CONSENT, FLORIDA ELDER CARE & WELLNESS, LLC MAY EMAIL ME ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, SUCH AS APPOINTMENTS REMINDER CARDS AND PATIENT STATEMENTS.

I HAVE READ THE RIGHT TO REQUEST THAT FLORIDA ELDER CARE & WELLNESS, LLC RESTRICTS HOW IT USES OR DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

THE PRACTICE HOWEVER IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF IT DOES, IS BOUND BY AGREEMENT. BY SIGNING THIS CONSENT FORM, I AM CONSENTING TO FLORIDA ELDER CARE & WELLNESS LLC USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURE IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, FLORIDA ELDER CARE & WELLNESS, LLC MAY DECLINE TO PROVIDE TREATMENT FOR ME.

_____ _____

Patient's Name **Date**

_____ _____

Patient's or Legal Guardian's Signature **Legal Guardian's Name**

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HIPAA ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF HIPAA RIGHTS

I DO HEREBY ACKNOWLEDGE THAT **FLORIDA ELDER CAR**E & WELLNESS HAS PROVIDED ME WITH A NOTICE OF ITS PRIVACY PRACTICES, AS REQUIRED BY FEDERAL LAW (HIPAA). I UNDERSTAND THAT **FLORIDA ELDER CARE** WILL, UPON REQUEST, PROVIDE ME WITH A COPY OF THE PRIVACY POLICY.

SIGNED: _____

DATE:_____

CONFIDENTIALITY NOTICE

IT IS IMPORTANT FOR US TO HONOR THE CONFIDENTIALITY BETWEEN PATIENT AND PHYSICIAN.

PLEASE CHECK YOUR PREFERENCE BELOW.

_____YOU MAY DISCUSS MY MEDICAL INFORMATION ONLY WITH ME.

_____ I GIVE MY PERMISSION TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

1. _____

RELATIONSHIP:_____

2. _____

RELATIONSHIP:_____

YOU MAY LEAVE MEDICAL INFORMATION (TEST RESULTS, APPOINTMENT TIME, ETC.) ON MY VOICEMAIL AT:"

CELL: _____

HOME:_____

Florida Elder Care & Wellness

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PATIENT FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by Florida Elder Care & Wellness, I will pay my account at the time services rendered or will make financial agreements satisfactory to Florida Elder Care & Wellness. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Florida Elder Care & Wellness. All copayments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency. I agree to pay any collection agency fee that may be incurred.

I understand Florida Elder Care & Wellness contracts with health care service plans that relate only to items and services which are covered by the healthcare service plans. Accordingly, the undersigned accepts full responsibility for all Items or services, which are determined by the healthcare service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan,or in the benefit summary the health care plan furnished to the patient.

If your insurance has designated a primary care physician, you are required to have a prior authorization from your PCP prior to your office visit. If the authorization is not provided, whether by yourself or through your insurance carrier, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Self-pay account are patients who are covered by carriers that the practice does not participate with, or patient without an insurance card on file or at the time of service.The undersigned agrees that I am individually obligated to pay the full charges at the time of service.

I agree to pay the difference my primary insurance does not cover. The financial obligations of patients who are insured by carriers with which the practice does not participate in are considered a self-pay account. It's your responsibility to inform us of any changes with your insurance carriers, to confirm the practice's participation, and your eligibility prior each visit.The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Florida Elder Care & Wellness if I belong to a plan in which Florida Elder Care & Wellness does not participate with.

All returned checks will be assessed a $20 fee.

_____ _____

Signature of Patient or Authorized Party Date

Florida Elder Care & Wellness
We Care About You

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Florida Elder Care, & Wellness LLC is required to provide Patient with a copy of Private Practice's Notice of Privacy Practices ("Notice"), which states how Private Practice may use and/or disclose Patient's health information. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Please sign this form to acknowledge receipt of the Notice. By signing this form, you also acknowledge that the privacy policy has been made available to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Patient may refuse to sign this acknowledgement, if Patient wishes.

I acknowledge that I have received a copy of Private Practice's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____

Print Patient's Name

FOR OFFICE USE ONLY

Private Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

☐ Patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.

☐ Private Practice was unable to communicate with Patient.

☐ Other:

Florida Elder Care & Wellness

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CONSENT FOR CHRONIC CARE MANAGEMENT

As a patient with two or more chronic conditions, you may benefit from a new program that Florida Elder Care & Wellness offers all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year. Your assigned clinician in charge of your care is Susan Conley, APRN. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care. You agree and consent to the following: As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information. We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is $42, of which your portion will be $8. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month. Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice. You have a right to: A Comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible. Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice. I agree to participate in the Chronic Care Management program. Yes ____ No_____

_____ _____

Patient or Authorized Party Signature Date

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TELEHEALTH CONSENT

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Skype, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Additionally, in rare circumstances security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.
I do hereby consent to allow my provider to record any or all
parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits.

I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation, and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

I understand that I have a right to request copies of such recordings and have the right to revoke this authorization in writing at any time during the course of my treatment.
I understand that this
authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.

_____ _____
Patient Signature / POA Date

_____
Print name