Visiting Physicians Association®
Bringing Integrated Health Care Home™

GENERAL CONSENT FOR TREATMENT

Patient Authorization for the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation

CONSENT TO VISITING PHYSICIANS ASSOCIATION FOR SERVICES

I request and authorize medical care as my physician, his assistant or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my physician(s) and that other personnel render care and services to me (the patient) according to the physician(s) instructions.

- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize **Visiting Physicians Association ("VPA")** to dispose of the bodily fluids.
- I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) test may be performed on me without my consent if a health professional or Visiting Physicians Association employee or First Responder sustains an exposure to my blood or other body fluid.
- HIV testing/screening may be performed with verbal explanation and consent. VPA does not offer anonymous testing. If you request an anonymous HIV test, then VPA can assist you in locating a facility which does such. You have the right to withdraw your consent for the test at any time before the test is complete. You have the right to ask questions and have them answered prior to the test and after results are reported. Screening for Hepatitis or other infectious diseases may also be performed with a verbal consent. VPA will report all positive test results to the Department of Health or other agency, as determined by state and local regulations.
- A drug screen by blood or urine sample may be obtained with verbal consent for purposes of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The Visiting Physicians Association **Notice of Privacy Practices** provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ATC) and acquired immunodeficiency (AIDS); including substance abuse treatment records protected under the regulation 42 Part 2, in the Code of Federal Regulations (if any); and psychological and social services records, including communication made to me to a social worker or psychologist (if any) may be disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the local Visiting Physicians Association office.

- I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or healthcare operations. My physician(s) and Visiting Physicians Association are not required to agree to this restriction, but if they agree, will be bound by the agreement.
- By signing this form, I acknowledge that I have been offered and/or received the Visiting Physicians Association **Notice of Privacy Practices**.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I understand that as part of my healthcare, **Visiting Physicians Association**, originates, maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my medication history and formulary benefits may be downloaded from a secure electronic clearinghouse. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I acknowledge that a copy of Notice of Privacy Practices was provided to me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that **Visiting Physicians Association** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Visiting Physicians Association** reserves the right to change its notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation. Should **Visiting Physicians Association** change its notice, it will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, via email).

I authorized the release of health information to the individual named below for the purpose of: _____

Name: _____ Relationship: _____

Address: _____

I wish to have the following restriction with regard to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand and acknowledged that I received a **Notice of Privacy Practices**, and I consent to such disclosures as delineated in the Notice.

I understand that this may include information relating to: (check and initial if applicable)

- ❑ Acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV)
- ❑ Behavioral health service/psychiatric care
- ❑ Treatment for alcohol and/or drug abuse

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to Visiting Physicians Association for benefits (payments) otherwise payable to me. **I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts.**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

- ❑ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**
- ❑ Consent of Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____