Practitioners-In-Motion Patient Consent

_____ _____ _____ ____/____/_____ Gender_____ ____/____/_____

Last Name **MI** **First Name** **Date of Birth** **Social Security**

_____

Address **Apt #** **City** **State** **Zip Code**

_____ _____ _____

Location/Facility **Home Phone** **Cell Phone**

_____ _____ _____

Emergency Contact Person/Guardian **Relationship to Patient** **Emergency Phone**

_____

Address **Apt #** **City** **State** **Zip Code**

************************************Please fill above out completely before sending************************************

Name of Primary Insurance Company Telephone Number Policy Number Group Number

_____ _____ _____ _____

Name of Secondary Insurance Company Telephone Number Policy Number Group Number

_____ _____ _____ _____

Responsible Party For Payment? No or Yes – Subscribers Name_____

Address Apt # City State Zip Code

_____

AUTHORIZATION AND CONSENT TO TREAT

*I hereby authorize Practitioners In Motion representatives to provide services and treatments for any medical condition
*I consent and authorize representatives/employees of Practitioners In Motion to provide timely and appropriate medical care services in the home setting.
*I understand and accept responsibility of participating and cooperating in my care and acknowledge that no guarantee is made regarding the results of services provided.
*I understand that all representatives/employees will be adequately experienced, licensed health care professionals.
*I reserve the right to refuse services or treatment at any time upon giving verbal notification to the practice or service team member.
I understand the practice reserves the right at all times to cease providing services upon verbal or written notification.

Signature of Patient/POA/Guardian_____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read it if so I chose) and understand the notice. I understand that a signed copy of this signature page will be placed in my chart to reflect that have received the entire notice.
Do not release or discuss patient information with_____

Signature of the Patient/POA/Guardian_____ **Date**_____

MEDICAL RECORDS RELEASE ASSIGNMENT OF BENEFITS

I hereby authorize this office to release any necessary information for the purpose of payment of insurance claims. I hereby authorize the disclosure of my medical and insurance information to this office for the purpose of my care or to ensure payment from the insurance company. I hereby assign insurance payments directly to this office otherwise payable to the insured. I understand first I am financially responsible for all charges whether or not paid by my insurance. I agree to allow a copy of this authorization to be used in place of an original.
This information may be faxed/mailed to :_____

Signature of the Patient/POA/Guardian_____ **Date**_____
Signature of Insured_____ Date_____

Practitioners In Motion, PLLC 2263 W. New Haven Ave #350 West Melbourne, FL 32904
Office: 321-216-2288 Fax: 321-216-2255

PRACTITIONERS IN MOTION

"BRINGING MEDICAL CARE TO YOU"

PRACTITIONERS IN MOTION

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from Practitioners In Motion please complete this form. Initial one:

_____ (initial) Practitioners In Motion is permitted to share **any and all** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

_____ (initial) Practitioners In Motion is permitted to share **any** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits except:
_____

_____

Persons authorized to receive my medical information (full name, relationship, and phone number):

NAME	**RELATIONSHIP**	**PHONE NUMBER**

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine, (Phone number_____)

_____ Message on work voicemail (Phone number_____)

_____ Message on cell phone (Phone number_____)

_____ Email address_____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing:

_____ _____

Patient-Print Name Signature

DOB:_____ Date:_____

This authorization is **not** valid for the request of printed copies of your medical records. Only you (or legal representative) must sign a Health Information Release Form to obtain copies of your medical records.

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please print and fill out both forms.
Then scan, and fax to (321) 216-2255
or email to PractitionersinMotion@gmail.com