1820 43rd Ave
Suite B Vero Beach, Florida 32966

New Patient Policy

Dear Patient,
We look forward to seeing you in our office. Thank you for giving us the opportunity to care for your medical needs. In order for us to provide you with the best care possible, we must follow a few guidelines and government regulations.

Office Hours: Monday through Thursday 8am – 4pm and Friday 8am -12pm, Saturdays are scheduled by appointment only.

Private Insurance: Hometown HealthCare does not accept private insurance currently.

Self Pay: Hometown HealthCare requires payment at the time of service. Any questions regarding payment arrangements please see the office manager.

Collections: All unpaid balance will be sent to an outside collection agency or small claims court, after all practice efforts have been exhausted. Any and all small claims and collections cost will be the patient's responsibility.

Return check fee: A fee of $25.00 will be charged to any patient account for a returned check.

Appointment: Appointments cancelled within 24 hours and no call/no show appointments will result in a $25.00 fee charged to the patient account for a missed appointment.

Fee for completing forms: A fee of $35.00 will be charged to the patient at the time of service.

Medical Records Release & authorization for Use or Disclosure of Protected Health Information:
I authorize Hometown HealthCare and staff to disclose all pertinent Protected Health Information to healthcare providers involved my medical care and treatment. I understand that only pertinent Protected Health Information will be disclosed to my healthcare providers. I understand that Protected Health Information is information related to medical treatment and medical care and I understand that this information cannot be disclosed without my approval. Furthermore, I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or ordered pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient's Consent
(for use and disclosure of protected health information to carry out treatment, payment, or health care operations)

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I agree to allow Hometown HealthCare to use or disclose protected health care information of the listed patient to carry out treatment, payment, or health care operations.
I have been informed of the Privacy Notice. The notice is a more complete description of the uses and disclosures of protected health information that may be made, and of my rights with respect to protected health information.

1. I have received a copy of the privacy notice.
2. I understand that I have the right to review the notice before signing this consent.
3. I understand that the terms of the privacy notice may change, and that I have the right to request a revised copy of the notice.

I understand that I have the right to request a restriction on how protected health information is used or disclosed in order for Hometown HealthCare to carry out treatment, payment and healthcare operations. Further, I understand that this request for restriction must be in writing and if the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to a requested restriction. I also understand that the office may call my home to confirm information and will mail statements to the address I have listed, which is part of the healthcare operations of Hometown HealthCare.

Photograph Consent Form:
I give consent to Hometown HealthCare and staff for any photography that may need to be obtained during my treatment. I understand this information will be kept in my chart.
I, the undersigned agree to all the above, I also agree to be responsible for any charges incurred by me or not payable by my insurance company. I also agree to be responsible for any legal fees and/or court costs incurred as a result of my failure to pay for services rendered.

Patient Name: _____ DOB: _____

Patient Signature: _____ Today's Date: _____