# *Practitioners In Motion PLLC*
# *Consent Form*

_____ _____ _____ ____/____/_____ Gender____ __ ____/____/_____

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

_____

**Patient Residence/ address** **Apt #** **City** **State** **Zip Code**

_____ _____ _____

**Location/Facility Name** **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** if 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 the 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 always reserves the right to cease providing services upon verbal or written notification**. Initial_____**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I will be provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read it if so I chose) upon request 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 this notice. **Initial_____**

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, 1785 WAVERLY PL SUITE A MELBOURNE FL, 32901
O: 321.216.2288 F: 321.216.2255 E: PRACTITIONERSINMOTION@PIMNP.COM

# *Practitioners In Motion PLLC*
# *HIPAA Compliance Form Information Form*

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 **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 for 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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