House Call
Medical Services
Primary Care at Your Door

Consent to Treat:
I hereby consent to receive treatment and/or services from House Call Medical Services, LLC. I understand and acknowledge that no specific outcomes or guarantees have been made regarding the results of the treatment and/or services provided.

Insurance Payment(s):
I understand that House Call Medical Services, LLC will bill my insurance for medical and/or psychiatric services provided. I acknowledge that I am responsible for any co-pays, deductibles, or out-of-pocket expenses that my insurance does not cover. I agree to notify House Call Medical Services, LLC promptly of any changes to my insurance coverage. I authorize House Call Medical Services, LLC to accept direct payment from my insurance company. Additionally, I consent to the disclosure of necessary clinical information to my insurance company or its authorized representatives for the purpose of processing claims and reimbursement for services rendered.

Financial Agreements:
I understand that I am responsible for all fees associated with my care, regardless of insurance coverage. If I have an unpaid balance with House Call Medical Services, LLC and do not make appropriate payment arrangements, my account may be sent to a collection agency. I agree to cover any fees charged by the collection agency, including up to a 35% fee based on the amount owed, as well as any reasonable costs, including attorney's fees, incurred during the collection process.

I authorize House Call Medical Services, LLC, and its designated collection agency, to contact me regarding my account. This may include communication via telephone, including calls to my wireless number (which may result in charges), text messages (standard message and data rates may apply), or emails to any address I provide. I also consent to receiving communications through pre-recorded messages or automatic dialing systems, as applicable. Furthermore, I authorize the collection agency to share my personal contact and account information with third-party vendors for the purpose of providing account-related notifications via telephone, text, email, or mail.

Convenience and Missed Appointment Fees:
House Call Medical Services, LLC charges a nominal $20 convenience fee for each home visit. This fee helps offset fuel expenses and travel time for the provider. To simplify payment, I agree to provide a credit card number to keep on file. By signing this form, I authorize House Call Medical Services, LLC to process the convenience fee within five (5) business days of my scheduled appointment. If I prefer to pay by cash or check, I will arrange this payment in advance, ensuring my account remains in good standing.
****The convenience fee is not charged to patients that live in a senior living facility*****

A missed appointment fee of $40 will be assessed for appointments not canceled or rescheduled at least 24 hours in advance. This fee must be paid before scheduling any future appointments. Three (3) or more missed appointments may result in termination from the practice. I acknowledge that telemedicine appointments are available and may be an option to reduce the need to reschedule in-person visits. Patients may be required to pre-pay the convenience fee of $20 at time of confirmation for future appointments as deemed necessary by House Call Medical Services, LLC.

Last Updated: 01/30/2025

Credit Card Information: ***not required for patients living in a senior living facility****

Cardholder's Name: _____
Card Number: _____
Expiration Date: ____/____ (MM/YY) CVV: _____
Billing Address: _____ City: _____
State/Province: _____ Zip/Postal Code: _____

Counseling Consent:
I understand that to receive the greatest benefit from therapy, I must commit to attending sessions on a regular basis. Confidentiality is a cornerstone of effective therapy, and all information gathered during the process will be kept confidential. I acknowledge that this information may only be shared with others involved in my care, such as medical providers, or when legally required.

Consent for Artificial Intelligence (AI) Transcription:
I understand that House Call Medical Services, LLC may use Artificial Intelligence (AI) - powered transcription services to document conversations and sessions during my treatment. I consent to the use of such technology for the purpose of accurate record-keeping and improving service quality. I acknowledge that these transcriptions will be handled confidentially and in accordance with applicable privacy laws. I also understand that these transcriptions will be stored securely and will only be accessible to authorized personnel involved in my care.

Patient Privacy and HIPAA Compliance:
We are committed to protecting your personal health information in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Your medical records and personal health information will only be used for treatment, payment, and healthcare operations.

Patient Information:
Name of Patient (Printed): _____
Date of Birth: ____/_____/_____
Social Security Number: _____-_____-_____

Patient Signature: _____ Date:_____

Patient Representative: _____ Date:_____

Last Updated: 01/30/2025