Mending Hearts Primary Care, LLC

7901 4th ST N #8298,
St. Petersburg Fl 33702
Phone: (813)-278-1241 Fax (833)-450-5156

Consent to Treatment/Healthcare Agreement

FINANCIAL RESPONSIBILITY:

I hereby authorize Mending Hearts Primary Care, LLC, or its affiliates to release any information acquired during my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, worker's compensation carriers, adjusters or attorneys**. I allow Mending Hearts Primary Care, LLC or its affiliates to appeal any claim resulting in denial of payment on my behalf. I understand that all charges or co-payments, if applicable are due at the time of services**. The patient is responsible for all fees regardless of insurance coverage, unless the services are covered under a contractual agreement between this medical practice and the patient's insurance carrier. I instruct and direct my insurance carrier(s) to pay Mending Hearts Primary Care or its affiliates by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined to be my responsibility, including by my insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for the services not covered by insurance. In addition, I understand I am responsible for making sure Mending Hearts Primary Care, LLC has all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges billed to you.

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Patient or Authorized Representative Initials

RELEASE OF INFORMATION:

I, hereby authorize Mending Hearts Primary Care, LLC, its affiliates and its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to Mending Hearts Primary Care, LLC. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

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Patient or Authorized Representative Initials

CONSENT TO TREATMENT:

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the legally authorized representative for whom I am signing and understand that no guarantee or assurance has made as to the results for which may be obtained. I understand that Mending Hearts Primary Care utilizes Physician Assistants/Nurse Practitioners for levels of practice approved by the state medical board. I understand and agree to receive services provided by such practitioners when necessary and appropriate.

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Patient or Authorized Representative Initials

PHOTO DOCUMENTATION:

I hereby grant authorization and consent for Mending Hearts Primary Care, LLC to make a copy of my photo identification to be included in my confidential record as well as to take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury, clinical conditions or procedure that they feel is medically necessary to include in my confidential medical record.
A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

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Patient or Authorized Representative Initials

I authorize the release of any medical information necessary in coordination of my medical treatment/care.

Name of Patient (Print only) **Signature of Patient, DPOA, Guardian/Authorized Agent**

Relationship to Patient **Date** **Witness Signature**

I would like a copy of this form for my records ☐ **No** ☐ **Yes**