Physician House Call Service
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8280 Willow Oaks Corp Drive Fairfax VA 22031

GENERAL CONSENT FOR TREATMENT

Patient Consent to the Use and Disclosure of Health Information for the Purposes of Treatment, Payment, and Healthcare Operations

CONSENT FOR SERVICES TO DMV Medical Concierge

I request and approve medical treatment from DMV Medical Concierge as my physician, his assistant, or designees (collectively referred to as "the physicians") consider required or advisable. Routine diagnostics, radiology, and laboratory tests, administration of routine medications, biological and other therapeutics, and routine medical and nursing treatment are all examples of this type of care. In an emergency, I allow my physician(s) to perform other additional or extended services if it is necessary or advisable to save my life or health. I recognize that my (the patient's) treatment is directed by my physician(s), and that other staff provide care and services to me (the patient) as directed by my physician(s).

• I understand that medicine and surgery are not exact sciences, and I understand that no assurances or commitments have been made to me about the outcome of any diagnostic operation or treatment.

• I recognize that during routine diagnostic procedures, samples of body fluids and/or tissues can be taken from me (the patient).

• I have been told and understand that if a health professional, DMV Medical Concierge employee, or First Responder comes into contact with my blood or other bodily fluids, an HIV (human immunodeficiency virus – AIDS) test can be conducted on me without my permission.

• HIV testing/screening may be done with verbal consent and clarification. The National Health Care Plan does not have anonymous testing. If you need an anonymous HIV screening, DMV Medical Concierge will help you find a facility that can provide it. Before the test is completed, you have the right to withdraw your consent for the test. Prior to the test and after the results are published, you have the right to ask questions and have them answered. With verbal approval, screening for Hepatitis or other infectious diseases is also possible. All positive test results will be reported to the Department of Health or another entity as required by state and local regulations.

• With verbal consent, a drug screen by blood or urine sample can be obtained to verify compliance with prescription regimens, or when abuse or misuse is suspected, or when signs or symptoms of toxicity are present.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The DMV Medical Concierge Notice of Privacy Practices explains how protected health information about me (the patient) is treated, including information about the human immunodeficiency virus (HIV), AIDS-related complex (ATC), and acquired immunodeficiency (AIDS); and substance abuse treatment records protected under 42 Part 2 of the Code of Federal Regulations (if applicable). Before signing this consent, I was given the opportunity to review the Notice. I recognize that the terms of the Notice are subject to revision, and I understand that I can obtain a revised copy by contacting the nearest DMV Medical Concierge office**.**

• I agree that I have the right to seek limits on the use or disclosure of my protected health details for treatment, payment, or healthcare operations. My doctor(s) and DMV Medical Concierge are not required to adhere to this restriction, but if they do, they will be bound by it.

• By signing this document, I accept that the DMV Medical Concierge Notice of Privacy Practices has been offered to me and/or that I have obtained it.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I agree that DMV Medical Concierge creates and preserves paper and/or electronic documents detailing my medical history, symptoms, diagnosis and test results, treatments, treatment, and any arrangements for potential care or treatment as part of my healthcare. I recognize that a safe electronic clearinghouse can be used to download my prescription history and formulary benefits. I acknowledge that this information is confidential.

• A foundation for my care and treatment

• A way for the various health practitioners involved with my treatment to communicate with one another.

• A way for a third-party payer to check that services paid were actually delivered

• A tool for routine healthcare operations such as evaluating quality and checking the competence of healthcare professionals

I acknowledge that a copy of Notice of Privacy Practices was provided to me. I understand that I have the following rights and privileges:

• Prior to signing this consent, you have the right to review the notice.

• The right to object to the use of my health information for directory purposes;

• The right to request limitations on how my health information can be used or reported in the course of treatment, payment, or healthcare operations.

I recognize that DMV Medical Concierge were under no obligation to agree to the requested restrictions. I accept that I have the right to withdraw this consent in writing, unless the organization has already taken action in reliance on it. I understand that if I fail to sign or revoke this consent, this organization will refuse to treat me in accordance with Section 164.506 of the Code of Federal Regulations.

I also recognize that, in compliance with Section 164.520 of the Code of Federal Regulations, DMV Medical Concierge reserves the right to change its notice and practices. If DMV Medical Concierge changes its notice, a copy of the new notice will be sent to the address I given (whether U.S. mail or, if I agree, via email).

I authorized the release of health information to the individual named below for the purpose of:_____

Name:_____

Relationship:_____

Address:_____
_____

I wish to have the following restriction with regard to the use or disclosure of my health information:_____
_____
_____
_____

I recognize that it may be appropriate to reveal my protected health details to another agency as part of this organization's treatment, payment, or healthcare operations, and I agree to such disclosure for these approved purposes, including fax disclosures.

I accept and recognize that I received a Notice of Privacy Practices, and I agree to the disclosures outlined in the Notice.

I am aware that this will provide details about: (check and initial if applicable)

☐ Acquired immunodeficiency syndrome (AIDS), Human immunodeficiency virus (HIV)

☐ Behavioral health service/psychiatric care

☐ Treatment for alcohol and/or drug abuse

ASSIGNMENT OF INSURANCE BENEFITS

I certify that the information I presented in applying for payment under TITLE XVII of the Social Security Act is right, and I seek all approved benefits on my behalf.

I hereby allow and order my insurance provider to pay that DMV Medical Concierge directly for benefits (payments) that would otherwise be due to me. Any costs not covered by or received from any insurance program, including any deductibles and coinsurance amounts, will be paid by me directly.

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign

☐ Consent of Caregiver if patient is unable to sign

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____

Date: _____ Time: _____

Signature of Witness: _____ Date: _____