General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

The privacy of all communications between you and your treatment provider is protected by law. Information can only be released to others with your written permission, with only a few exceptions. In some legal proceedings, a judge may order the testimony of your provider if he/she determines that the issues demand it. If your provider believes that a child, elderly, or disabled person is being abused or has been abused, they may be required to make a report to the appropriate state agency. If your provider believes that you are an imminent risk to the safety of yourself or others, they may be required to notify the potential victim(s) and local law enforcement to take protective actions. Your provider will attempt to fully discuss these situations with you before taking action.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name of Patient	**Date:**
Signature of Patient or Personal Representative	**Relationship to Patient**

APTIVA HEALTH

PATIENT INFORMATION

First Name: _____ M.I. ___ Last Name: _____ DOB: _____

Address: _____City: _____State: _____ Zip: _____

Cell:_____ Email:_____ SS#: _____

Sex: ☐ Male ☐ Female Emergency Contact_____ Phone:_____

Location of Pain/Injury:_____

PCP: _____ Name of attorney (if represented): _____

Date of Injury: _____ Is injury related to: ☐ MVA ☐ Work ☐ Fall ☐ Sports ☐ Health

AUTO/WORK INSURANCE INFORMATION

Did you have auto insurance at time of injury (if MVA): ☐ Yes ☐ No Have you filed a claim? ☐ Yes ☐ No

Auto Insurance Co: _____ Are you the policy holder? ☐ Yes ☐ No

Claim Number: _____ Adjuster: _____

Adjuster's Phone Number: _____ Extension: _____

By providing this information you understand that your auto insurance provides personal injury protection (PIP) benefits as part of your auto insurance policy. Your auto insurance will be billed for any healthcare provided to you related to a motor vehicle accident. You understand that your auto insurance is billed regardless if you were at-fault for the motor vehicle collision (this is why Kentucky is called a "no fault" state).

HEALTH INSURANCE INFORMATION

Insurance Name: _____ Policy holder name: _____

PCP Name: _____ PCP Phone: _____

ID#: _____ Group#:_____

I understand that health and insurance policies are an arrangement between the insurance carrier and myself: I authorize payment from my insurance carrier directly to this office with the understanding that all money will be credited to my account upon receipt. I state that all the above information is true and accurate.

Patient Signature: _____ Date: _____

********** FOR INTERNAL OFFICE USE ONLY **********

ER Records requested on: _____ **ER Records received on:** _____

Has patient met deductible? ☐ Yes ☐ No -- Specialist Co-Pay: _____ Generalist Co-Pay: _____

APTIVA HEALTH

Patient Name:_____ **DOB:**_____

Reason for appointment: _____

PAST MEDICAL HISTORY

No significant past medical history ☐ none (*skip to Social History if none*)

Have you been diagnosed with or had any of the following?

	Yes	No		Yes	No
Arthritis			Hepatitis		
Asthma			HIV		
Back pain			High-blood pressure		
Cancer			Inflammatory		
COPD			Jaundice		
Coronary artery disease			Migraine		
Diabetes Mellitus			Seizure		
GERD			Tuberculosis		

Any other significant history? _____

Any metal implants (i.e. joints) or implanted devices (defibrillators, artificial lens)? _____

Are you being treated with pain medication or in pain management? ____Yes ____No

SOCIAL HISTORY

Are you Pregnant? ____Yes ____No Do you smoke? ____Yes ____No If yes, how many packs a day? _____

Do you drink alcoholic beverages? ____Yes ____No If yes, how often _____

Do you use illegal drugs? ____Yes ____No Have you used illegal drugs in the past? ____Yes _____No

FAMILY HISTORY

☐ None or noncontributory

☐ Yes Please List: _____

Additional details: _____

SURGICAL HISTORY

Type of surgery?	Year

Patient Name:_____ **DOB:**_____

MEDICATIONS

Are you allergic to medication? ☐ Yes ☐ No

If yes, list: _____

Please list all medication, vitamins, or supplements that you are currently taking:

Name	Dose	Frequency	Condition

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions.

I, _____, hereby acknowledge that Aptiva Health has made available a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how l can access this information. I understand that if I have questions or complaints, I may contact:

Office Manager – 1-844-999-DOCS (3627)

I also understand that I am entitled to receive updates upon request if Aptiva Health amends or changes its Notice of Privacy Practices in a material way.

Patient's name if not signed by patient: _____

Authorized Signor if patient is a minor: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY APTIVA HEALTH IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgment.

☐ Other (specifiy):_____

Name and title of employee: _____ Date: _____

APTIVA HEALTH

FINANCIAL AGREEMENT AND AUTHORIZATIONS

I, _____, do hereby authorize Aptiva Health, LLC (hereinafter "Aptiva"). to furnish my legal representative, with a full report of my examination, diagnosis, treatment, prognosis, and complete patient file.

I fully understand and agree that I am directly and wholly responsible to Aptiva for all medical bills submitted for services rendered to me, and that my obligation for payment to Aptiva is absolute and continuing until any outstanding charges owed to Aptiva are satisfied in full.

I agree that if I, or anyone acting on my behalf, receives funds from any third person or insurance company, whether by settlement, judgment, verdict, award, or claim payment or reimbursement, or otherwise, as payment, reimbursement, or compensation for the medical bills for services rendered to me, that Aptiva shall be entitled to payment from any such funds for the payment for said medical bills. I hereby authorize and direct my attorney and/or legal representative or any person receiving said funds on my behalf to pay directly such sums as may be due and owing to Aptiva from any such funds. I further authorize and direct my attorney and/or legal representative or any person receiving said funds on my behalf to withhold such sums from any settlement, judgment, award, claim reimbursement and/or verdict as may be necessary to satisfy any outstanding amount owed to Aptiva for my medical treatment and care.

Authorization to Release/Obtain Information: By signing this authorization you are deemed to understand and permit Aptiva Health, or any of its affiliates, to release any information stated herein and any private or HIPAA protected information to my attorney, legal representative, insurance company, reparation obligor or any third-party investigator. Release of information may be conducted by mail, email, facsimile, telephone, or other electronic means. Aptiva, or any of its affiliates, may also interrogate your medication history, prescribed on unprescribed via KASPER or other means. Aptiva, or any of its affiliates, may also release information including the diagnosis, records, examination rendered, and claims information, between Aptiva and/or its affiliates.

Medicare: I hereby request that payment of authorized medical benefits be made to Aptiva, for any services furnished to me by any of those medical facilities. I authorize the release of any medical information about me, from any holder of said information, to the Health Care Financing Administration and its agents. That release encompasses any information needed to determine benefits payable for related services provided by Aptiva.

Commercial Insurance: I hereby authorize Aptiva to submit claims to my insurance carrier or its intermediaries for any and all covered services rendered and further DIRECT MY INSURANCE CARRIER AND ITS INTERMEDIARIES TO ISSUE PAYMENT BY CHECK DIRECTLY TO THE CHARGING FACILITY. I further authorize Aptiva to take any and all necessary steps, including but not limited to appealing denied claims and submitting any complaint or grievance on my behalf, in order to obtain payment from my insurance carrier.

I understand that I am wholly financially responsible for any balance not covered by my insurance carrier(s).

Patient Signature: _____ Date: _____

Medical Information Release Form (HIPAA Release Form)

Patient Name:_____ **DOB:**_____

Release of Information

[x] I authorize the release of information including the diagnosis, records, examination rendered, and claims information. This information may be released to:

_☐_ Spouse _____

_☐_ Child(ren) _____

_x__ Other __Aptiva Health_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call _☐_ my home _☐_ my work _☐_ my cell number: _____

If unable to reach me:

_☐_ you may leave a detailed message

_☐_ please leave a message asking me to return your call.

_☐_ Other: _____

Signed: _____ Date:_____ /_____/_____

Witness signature: _____ Date: ____ /_____/_____

Patient Signature _____ Date _____Time _____

Office Staff Signature _____ Date_____ Time _____

****

If patient is a minor or unable to sign, please complete the following:

Signature_____ Relationship _____ Date_____

Office Staff Signature _____ Date_____ Time _____