



18000 W. 9 Mile Rd Ste. 525 | Southfield MI 48075

Phone: (248) 327-6196 | Fax: (877) 311-5596

PATIENT CONSENTS

CONSENT

- I give my consent and authorize medical treatment as deemed necessary and appropriate by the physicians of TRAVELING PHYSICIAN SERVICES PC, and their employees participating in my care.
- I authorize TRAVELING PHYSICIAN SERVICES PC to release pertinent information to my health insurance companies that is required during my examination or treatment. I also give my consent and authorize payment of all insurance benefits, including Medicare and Medicaid payments, be sent directly to TRAVELING PHYSICIAN SERVICES PC I understand that I am solely responsible for any medical or surgical changes incurred during my treatment that are rejected by my insurance company or are considered co-pays or deductibles as applicable.
- I also authorize TRAVELING PHYSICIAN SERVICES PC to contact me via phone or mail, including leaving messages, sending out letters, about my care provided it assists the practice in carrying out necessary treatments for me, or as required to ensure payment or other timely management of health-related benefits for myself.
- I consent in being automatically enrolled in the Chronic Care Management Program that will give me access to my provider, in return, it will allow my advanced practitioner and their designees to perform a CCM on my behalf. I understand that TRAVELING PHYSICIAN SERVICES PC will bill my insurance for this service, and that I am responsible for any copayment or deductible. I understand that I can revoke this permission at any time by notifying TRAVELING PHYSICIAN SERVICES PC in writing.
- I understand that I may revoke this consent in writing, as permitted by law, except to the extent that the practice has already made disclosures or provided treatment in reliance upon my prior consent. If I refuse to sign this consent, TRAVELING PHYSICIAN SERVICES PC has the right to decline to provide services and treatment to me

Signature: _____

Name: _____

Relationship: _____

Date: _____



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PATIENT CONSENTS FORMS

CONTRACT

- I agree not to sell or give any of my medication to another person. I understand that it is illegal and could result in being discharged.
- I agree that my prescription can only be given at my regular doctor visits. If I miss a visit/or cancel my appointment I cannot get my medication/prescription until the next doctor visit. (Unless a documented emergency occurs).
- I understand that narcotic medications will NOT be called in. I understand the DR will NOT refill any narcotic medication without a visit. NO early refills permitted.
- I agree NOT to get ANY other narcotic pain medicine from another doctor, unless an Emergency. I agree that ONLY the DR will prescribe my pain medicine. If narcotic pain medicine is prescribed in my name (after I sign this agreement) I could be discharged.
- I agree that the medication I receive is my responsibility. I agree to keep it in a safe, secure place. I agree that medication may not be replaced if lost or stolen.
- I agree to take my medication as instructed and not to change (increase or decrease) the way I take my medication without first asking my doctor.
- I agree NOT to take any benzodiazepam medications (Valium, Klonopin, Xanax, etc.) unless authorized/prescribed by the DR or under emergency conditions at a hospital.
- I understand that medication alone is not sufficient treatment for my condition. Other treatments, including Physical Therapy or even possible intervention/injections, and/or surgery may be recommended as part of my treatment.
- I agree not to take any other narcotics/*pain medicine, cocaine, or addictive/illegal substance(s). *Unless a hospital emergency, and then I will notify Traveling Doctor's office with the hospital information
- I agree to provide random *urine samples. I understand that Michigan Guidelines for prescribing narcotic pain medicine include urine monitoring. If I refuse to provide urine for this purpose, the DR is NOT required to prescribe my pain medicine AND I may be discharged. *Dialysis patients agree to provide blood samples for monitoring.
- I agree NOT TO TAKE SOMA; I understand the DR DOES NOT prescribe XANAX, due to its high abuse potential. The DR may prescribe a similar medication (Klonopin, Valium or other safer "cousins" to Xanax) if needed for short term severe anxiety. No cough syrup with Codeine will be prescribed, especially with pain medicine.
- I agree if I use marijuana, TPS PC is not responsible for any interaction with my other medications.
- I understand if I make suicidal statements, TPS PC is legally bound to call 911
- I agree that any rude, in appropriate or threatening behavior to the doctor, company staff, or the pharmacy may result in being discharged
- I understand that violations of the above may be grounds for termination of treatment.

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PATIENT CONSENTS FORMS

DISCLOSURE

● **Treatment**

Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

● **Payment**

Your health information may be used to seek payment from you health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may used to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

● **Health Care Operations**

Your health information may be used as necessary to support the day-to-day activities and management of TRAVELING PHYSICIAN SERVICES PC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

● **Law Enforcement**

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

● **Public Health Reporting**

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to Michigan's public health department.

● **Appointment Reminders**

Your health information will be used by our staff to make appointment reminders. Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may interest you.

● **Medical Information**

I authorize TRAVELING PHYSICIAN SERVICES PC to RELEASE AND OBTAIN information regarding my medical treatment contained in my patient records including: information about communicable diseases and infections, as defined by statute and the Michigan Department of Public Health Rules. Alcohol and Drug Abuse Treatment information protected under the regulations in 42 Code of Federal Regulations (CFR), Part 2. Mental Health treatment Records, psychological services, and social services information including communication made by social workers, psychologists or similar mental health professionals.

● **Other Uses**

Disclosures of your health information or its used for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure that occurred before you notified us of your decision.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED OF MY RIGHTS PERTAINING TO THE CONFIDENTIALITY OF MY TREATMENT AND RECORDS UNDER 42 CFR PART 2, AND I UNDERSTAND THOSE RIGHTS. THIS RELEASE IS VALID FOR 1 YEAR AND MAY BE REVOKED IN WRITING AT ANY TIME, BUT MAY NOT AFFECT RETROACTIVE EXCHANGE OF INFORMATION. THE PERSONS TO WHOM INFORMATION IS DISCLOSED UNDER THIS AUTHORIZATION MAY POSSIBLY RE-DISCLOSE THE INFORMATION TO OTHERS WITHOUT PATIENT'S KNOWLEDGE OR CONSENT AND THEREFORE LOSE THE LEGAL PRIVACY PROTECTION

Signature: _____

Name: _____

Relationship: _____

Date: _____



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PATIENT CONSENTS FORMS

RIGHTS

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice. We have detailed policies and procedures that we follow to further assure the privacy rule is followed. RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Whatever the reason for these revisions, we will provide you with a revised notice in your next visit by giving you a copy or mailing you the new law. The revised policies and practices will be applied to all protected health information that we maintain.

TRAVELING PHYSICIAN SERVICES PC reserves the right to modify the privacy practices outlined in the notice.

Signature: _____

Name: _____

Relationship: _____

Date: _____



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PATIENT CONSENTS FORMS

PRIVACY

- I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment and records under 42 CFR Part 2, and I understand those rights. This release is valid for 1 year, and may be revoked in writing at any time, but may not affect retroactive exchange of information. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore lose the legal privacy protection.
- I authorize TRAVELING PHYSICIAN SERVICES PC to RELEASE AND OBTAIN information regarding my medical treatment contained in my patient records including: information about communicable diseases and infections, as defined by statute and the Michigan Department of Public Health Rules. Alcohol and Drug Abuse Treatment information protected under the regulations in 42 Code of Federal Regulations (CFR), Part 2. Mental Health treatment records, psychological services, and social services information, including communications made by social workers, psychologists or similar mental health professionals.
- I hereby affirm that I have not received, nor have I been promised to receive, any payment, cash, money, gift, kickback, or other consideration, directly or indirectly, from any person or company (including any home care company) in return for my requesting any item, good, or service for my medical treatment either by (1) TRAVELING PHYSICIAN SERVICES PC, or by (2) any other healthcare provider, for which payment may be received in whole or in part under a Federal health care program.

Signature: _____

Name: _____

Relationship: _____

Date: _____



TRAVELING
PHYSICIAN
SERVICES

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AUTHORIZATION FOR RELEASE, PAGE 1 OF 2

This form ("Authorization") is to authorize TRAVELING PHYSICIAN SERVICES PC to obtain and use your protected health information ("Information") from the providers and facilities identified below. This Authorization is also used to authorize the providers and facilities identified below to disclose your Information. You are not obligated to sign this form or share your Information as a condition for receiving care and treatment

PATIENT INFORMATION

PRIMARY CARE PROVIDER _____

ACTUAL REQUEST

RECEIPT OF AUTHORIZATION FROM PATIENT

By my signature below, I, the above-listed patient (or the patient's authorized representative), authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf, to release Information to TPS PC. I further authorize the following healthcare providers and facilities specifically listed below, including those listed on Exhibit A attached hereto, to release my Information to TPS PC and to present this form without restriction or redaction to every provider listed on this form and on Exhibit A, for purposes of obtaining and using my medical records. I understand that signing this Authorization is voluntary and not a condition of receiving care and treatment from TPS PC.

PERMISSION ABOUT SPECIFIC HEALTH INFORMATION

I further understand and agree that these records may include information pertaining to the treatment of certain sensitive medical conditions. Unless identified below, I specifically give permission to share the following information in my record; information about mental health, psychological or psychiatric conditions, testing or treatment, information about HIV antibody and antigen testing, HIV/AIDS diagnosis or HIV/AIDS treatment, information about my sexually transmitted diseases, tuberculosis, hepatitis B or C, or genetic information and information about alcohol or drug treatment. If certain types of sensitive information are shared, I understand a specific notice required by 42 CFR, Pall 2 shall be included prohibiting the re disclosure of certain confidential information.



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AUTHORIZATION FOR RELEASE, PAGE 2 OF 2

PATIENT RIGHTS

The patient or the patient's legal representative agrees with the following statements:

My treatment, payment, enrollment or eligibility for benefits will not be affected if this Authorization is not signed.

I understand that this Authorization will expire upon my termination of care from TRAVELING PHYSICIAN SERVICES PC, unless sooner revoked in writing. I understand that I may revoke this Authorization at any time by notifying TRAVELING PHYSICIAN SERVICES PC in writing, but if I do, it will not have any effect on any actions taken before TRAVELING PHYSICIAN SERVICES PC received the revocation

I understand that there is potential that the recipient of the Information may disclose the Information in accordance with state and federal law and the Information may no longer be protected by those laws. I understand that I may inspect or obtain a copy of the information to be used or disclosed to the extent as provided for in 45 C.F.R. 164.524.

SUBMISSION OF MEDICAL INFORMATION

FAX:
(877) 311-5596

MAIL:
TRAVELING PHYSICIAN SERVICES PC
18000 W. 9 Mile Rd.
Ste. 525 Southfield, MI 48075

RELEASE SIGNATURE

The health information disclosed to you may be protected by Federal confidentiality rules (42 CFR Part 2), the HIPAA Privacy Rule, or by State laws. The Federal and State laws prohibit you from making any further disclosure of this information unless further disclosure IS expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or other laws. A general authorization for the release of medical or other health information IS NOT sufficient for this purpose. The Federal rules may restrict any use of the information to criminally investigate or prosecute any person seeking alcohol or drug abuse treatment. Federal rules restrict any use of the information to criminally investigate or prosecute the patient.