Mason-Dixon Mobile Medicine
www.masondixonmed.com
☎240.397.6723 🖷833-992-0865
Time for a home visit?

Global Consent (2022)

CONSENT TO TREAT

I hereby authorize and consent to the performance of the physical examination and treatment by a physician assistant, nurse practitioner or physician from *Mason-Dixon Mobile Medicine*. I understand that this consent is given in advance. This consent includes permission to review my prescription history with the SureScripts prescription database. This also includes orders for home visits for: nursing, physical therapies, occupational therapies, blood draws, urinalysis, x-rays, ultrasounds, EKGs, echocardiograms and other procedures. I understand that *Mason-Dixon Mobile Medicine* is not a 24-hour emergency service and has no guaranteed availability for emergencies. I understand that in the event of an emergency or urgent medical condition I, or my representative, must dial 911. Under no circumstances should I postpone the care or evaluation of an urgent or emergency condition waiting for a visit or return communication (phone call, e-mail, or fax) from providers at *Mason-Dixon Mobile Medicine*.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of *Mason-Dixon Mobile Medicine* Notice of Privacy Practices (NPP). I understand the NPP provides information about how protected health information about me may be used and disclosed in providing care to me and receiving payment for that care. I understand that the terms of the notice may change as allowed by law. I understand that I can review the NPP at *Mason-Dixon Mobile Medicine*'s website.

HEALTH INSURANCE ACKNOWLEDGMENT

I request that the payment of authorized Medicare/Insurance carrier benefits be made on my behalf to *Mason-Dixon Mobile Medicine* for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Centers of Medicare/Medicaid Services and its agent and/or other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services.

I understand that I am totally responsible for payment of my account unless *Mason-Dixon Mobile Medicine* has previously arranged by contractual agreement to accept payment in full for services (less copays, deductibles, co-insurance and/or non-covered services). I accept financial responsibility for all charges billed and the undersigned (jointly and severally) guarantee to pay all such charges. All bills are payable and become due on presentation. I agree if a payment of bills rendered is not made, and collection efforts are required, I hereby agree to pay and bills rendered to me together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due.

_____
Patient / Legal Representative Signature

_____
Relationship to Patient

_____
Printed Name of Patient

_____
Date