Hometown Physician Services
Patient HIPAA Acknowledgement, Consent for Services and Insurance

Patients Full Name:_____ Date of Birth:_____

Facility / Location: _____

_____ (Initials) **NOTICE OF PRIVACY PRACTICES**: I acknowledge I have received a copy of Hometown's Physician Services Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Hometown Physician Services may change its privacy practices in the future. If privacy practices change, I understand that the new privacy practices will be posted on Hometown Physician Services website and that I may request a copy of the new privacy practices at any time. I also understand that I can contact Hometown Physician Services Privacy Officer with any questions I may have about the Notice of Privacy Practices.

_____ (Initials) **RELEASE OF INFORMATION:** I hereby permit Hometown Physician Services and the physicians or other health professionals involved to release healthcare information for purposes of treatment, payment, or healthcare operations. I also consent to the release and disclosure of my health care information to health care providers and facilities unrelated to Hometown Physician Services that may be involved in my care.

INSURANCE ASSIGNMENT & PAYMENT CONSENT: I give permission to Hometown Physician Services to release my protected health information, including paper or electronic records of my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, to my Health Insurance Company, Health Maintenance Organization or Medical Assistance Program for the purposes of payment, treatment or health care operations. I understand that this information serves as a source of information for applying my diagnosis and treatment information to my medical bill; a verification to third party payers that I did in fact receive these health care services; and a tool for routine health care operations such as quality review of the staff performance at Hometown Physician Services.

PATIENT CENTERED MEDICAL HOME & CHRONIC CARE MANAGEMENT: I give Hometown Physician Services permission to enroll me in the Hometown Physician Services on-site primary care program. This care program includes physician/care management on-site visits, and related activities, which will be billed to my insurance with standard deductibles and copays.

This consent applies to health records that Hometown Physician Services already have about me, and information about future care I may receive from them. This consent will continue unless I cancel by giving written notice to Hometown Physician Services or it expires as required by law. If I cancel the consent, it will apply to information generated after the date when the notice to cancel is received.

_____

Patient's Name (or legal representative) **Date**

Hometown Physician Services Patient Portal Access (email address mandatory for access)

E-mail Address (or write decline): _____
(please indicate on line above if you do not want access to patient portal)

_____

Legal Representative **Relationship to Patient**

*Need copy of Medical POA or Healthcare Directive included.