Desta Anthony Mobile NP Adult Health, PLLC

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent and authorize Desta Anthony Mobile NP Adult Health to the evaluation, diagnostic procedures, testing, and treatment as directed my nurse practitioner. I understand that I may have some of these services provided under the direction of Desta Anthony, NP by nurse practitioner or nursing students affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

2. Consent to Release Information

I acknowledge that Desta Anthony Mobile NP Adult Health, PLLC may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that a Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Desta Anthony Mobile NP Adult Health, PLLC.

I acknowledge and consent to allow Desta Anthony Mobile NP Adult Health, PLLC to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Desta Anthony Mobile NP Adult Health, PLLC all rights, title and interest in payments from third-party payors. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit.

Initial HERE:

→_____**Failure to provide complete insurance information may result in patient responsibility for the entire bill**.

→_____**If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately** I understand and agree that I will be responsible for any deductible, co-pay or balance due that Desta Anthony Mobile NP Adult Health, PLLC are unable to collect from my third- party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Desta Anthony Mobile NP Adult Health, PLLC on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Desta Anthony Mobile NP Adult Health, PLLC. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Desta Anthony Mobile NP Adult Health, PLLC will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Desta Anthony Mobile NP Adult Health, PLLC

ACKNOWLEDGEMENTS

1. **Notice of Privacy Practices:**
   ☐ **I have reviewed and decline to keep paper copy** ☐ **I have received a copy**

2. **Patients' Rights and Responsibilities:**
   ☐ **I have reviewed and decline to keep paper copy** ☐ **I have received a copy**

3. **Advanced Directives:**
   ☐ **I have reviewed and decline to keep paper copy** ☐ **I have received a copy**

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING	Patient NAME:	DOB:
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 ANSWERED.	Patient or Authorized Representative SIGNATURE: Realtionship to Patient: DATE:	

Desta Anthony Mobile NP Adult Health, PLLC

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Desta Anthony Mobile NP Adult Health, PLLC

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations:

   Patient Name _____ Date of Birth_____

   Address_____

   _____

2. Information to be disclosed (check as many as appropriate):
   ___Complete health record(s), OR
   ONLY:
   ___History & Physical Examinations (most recent) ___Progress (Visit) Notes ___Consultation Reports
   ___Laboratory Tests (most recent)
   ___X-Ray Reports (most recent) ___Last Billing/Insurance Information

3. _____(Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. THIS PROVISION MUST BE INITIALED BY PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

4. This information is to be disclosed to (name & address) Information disclosed by (name & address)
   Desta Anthony NP _____
   8241 Penstock Way _____
   Manlius NY 13104 or by EMAIL to: desta@mobilenp.com _____
   for the purpose(s) of: Transfer of Care, or.
   - ❑ At the request of the patient

5. This authorization will expire on_____, not to exceed 1 year. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I fail to specify a date or otherwise revoke this authorization, this authorization will expire 1 year from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: **1.** Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

   Signed:_____ _____
   Patient Date

   _____ _____
   (OR) Legal Representative Date

   _____
   Print Name

Desta Anthony Mobile NP Adult Health, PLLC

TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ DOB: _____

1. I understand that my health care provider has recommended to me that I engage in a telehealth appointments when a house call is unable to be provided due to, but not limited to, isolation precautions, potential delay in care, inclement weather prohibiting travel to patient's home.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider may use devices such as a stethoscope or otoscope or other peripheral devices to assist in the examination.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and specialty health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty health care provider or the primary care provider.

6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

_____ _____

Patient or Authorized Representative Signature Date

A. Notifier: Desta Anthony, NP

B. Patient Name: **C. DOB:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. TRAVEL FEES** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare will not pay for the **D. TRAVEL FEES** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
TRAVEL FEES (please review with provider as this form may not apply to all coverage areas)	Not a covered service	$40 per visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Travel Fees** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Travel Fees** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Travel Fees** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D. Travel Fees** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Desta Anthony Mobile NP Adult Health, PLLC

MEDICAL HISTORY FORM

Name:_____DOB:_____

HT:_____ WT:_____ PHARMACY:_____

☐POA ☐HCP ☐MOLST - ☐DNR/DNI ☐CPR ☐NONE ☐COPY

Current Concerns:

IMMUNIZATIONS	**YES**	**NO**	**UNKNOWN**	**DATE**	**REFUSES**
COVID					
INFLUENZA					
PNEUMONIA					
TETANUS					
SHINGLES					

PAST MEDICAL HISTORY:

Do you now or have you ever had:

Diabetes
High blood pressure
__High cholesterol
__Hypothyroidism
__Goiter
__Cancer (type) _____
__Leukemia
__Psoriasis
__Angina
__Heart problems
__Heart murmur
__Pneumonia
__Pulmonary embolism
__Asthma
__Emphysema
__Stroke
__Epilepsy (seizures)
__Cataracts
__Kidney disease
__Kidney stones
__Crohn's disease
__Colitis
__Anemia
__Jaundice
__Hepatitis
__Stomach or peptic ulcer
__Rheumatic fever
__Tuberculosis
__HIV/AIDS

Other medical conditions (please list):

SOCIAL HISTORY:
Smoking
ETOH
Medical Marijuana/History of other recreational drugs
Marital Status
Level of School and Previous Occupation
Caffeine
Children

SURGICAL HISTORY:

Recent Hospitalization:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
__Recent weight gain; how much____
__Recent weight loss: how much____
__Fatigue
__Weakness
__Fever
__Night sweats

MUSCLE/JOINTS/BONES
__Numbness
__Joint pain
__Muscle weakness/Falls
__Joint swelling
Where?

EARS
__Ringing in ears
__Loss of hearing

EYES
__Pain
__Redness
__Loss of vision
__Double or blurred vision
__Dryness

THROAT
__Frequent sore throats
__Hoarseness
__Difficulty in swallowing
__Pain in jaw

HEART AND LUNGS
__Chest pain
__Palpitations
__Shortness of breath
__Fainting
__Swollen legs or feet
__Cough

NERVOUS SYSTEM
__Headaches
__Dizziness
__Fainting or loss of consciousness
__Numbness or tingling
__Memory loss

STOMACH AND INTESTINES
__Nausea
__Heartburn
__Stomach pain
__ Vomiting
__Yellow jaundice
__Increasing constipation
__Persistent diarrhea
__Blood in stools
__Black stools

SKIN
__Redness
__Rash
__Nodules/bumps
__Hair loss
__Color changes of hands or feet

BLOOD
__Anemia
__Clots

KIDNEY/URINE/BLADDER
__Frequent or painful urination
__Blood in urine

Women Only:
__Abnormal Pap smear
__Vaginal bleeding
__Hot flashes
__Abnormal Mammogram

PSYCHIATRIC
__Depression
__Anxiety
__Difficulty falling asleep
__Difficulty staying asleep
__Agitation/Aggression
__Poor appetite
__Mood swings
__Frequent crying
__Paranoid Thinking
__Thoughts of suicide / attempts
__Inappropriate Sexual behavior
__Irritability
__Poor concentration
__Racing thoughts
__Hallucinations
__Rapid speech
__Guilty thoughts
__Paranoia
__Mood swings
__Wandering
__Risky behavior

OTHER PROBLEMS:

FAMILY HISTORY				
	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				
Spouse -				

DME
__Walker
__Wheelchair
__Hospital Bed
__Oxygen
__CPAP/BiPAP
__Glucometer
__Other

OTHER PROVIDERS WITH OFFICE NAME:
__PCP
__CARDIOLOGY
__PULMONOLOGY
__NEUROLOGY
__GERONTOLOGY
__NEPHROLOGY
__HEMATOLOGY-ONCOLOGY
__PSYCHOLOGY/COUNSELLING
__HOMECARE AGENCY
__PERSONAL CAREGIVER
__OTHER

ALLERGIES:

MEDICATIONS: