PATIENT REGISTRATION CONSENT AND ACKNOWLEDGEMENTS (HIPAA)

CONSENT TO TREAT

I consent to Barry Point Family Care's (BPFC) physicians, practitioners, and other providers ("Provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment, and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives, and estimated duration of treatment as applicable. I understand hat I may withdraw consent to treatment and will inform the attending provider of any decision to terminate treatment. In the event of an emergency while receiving care at BPFC, I authorize BPFC staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by BPFC an payment is due on the date of service. If an insurance/health plan claim is filed by BPFC, I request that payment of all benefits be made directly to BPFC. I agree t pay for any services or out-of-pocket expenses which are not covered by my insurance. I acknowledge receipt and acceptance of BPFC's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should BPFC refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to BPFC's release of the patient's protected health information (PHI) for treatment, payment, and operations purposes in accordance with HIPAA. I acknowledge that BPFC may release medical records and PHI to the third-party health plan or payer, including Medicare, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all the patient's health care. BPFC may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies, and others. I have been provided with BPFC's Notice of Privacy Practices that further describes the use and disclosure of certain PHI by BPFC. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to BPFC sharing PHI with the following individuals:

Name: _____ Relationship:_____ Phone Number:_____
◯ Medical ◯ Billing ◯ All

Name: _____ Relationship:_____ Phone Number:_____
◯ Medical ◯ Billing ◯ All

Name: _____ Relationship:_____ Phone Number:_____
◯ Medical ◯ Billing ◯ All

ADVANCED DIRECTIVE FOR HEALTHCARE:

◯ I do not have an Advance Directive.
◯ I have an Advanced Directive and will provide a copy.

Print Patient's Full Name ***Patient's Date of Birth***

Print Name of Guarantor/Legal Representative ***Relationship to Patient***

Signature & Date Signed ***Witness to Signature if Applicable***