Advanced Mobile Healthcare, LLC
9505 West Central , Ste 104
Wichita, Ks. 67212
(316) 312-0002
Fax: (316) 854-5644
amhcare.com

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at Advanced Mobile Healthcare, LLC (AMH) that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the provider (and/or designated assistant) and carried out by members of AMH's staff and personnel. I also authorize to access to my medication history electronically from the national Surescripts database in order to streamline data entry, increase accuracy and enable my healthcare provider to make better informed decisions.

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to AMH all my rights, title and interest to medical reimbursement benefits under my insurance policy (s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to AMH, with regard to my treatment and care with this AMH practice.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize AMH to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I have received and have been presented with the opportunity to review the AMH Financial Policy. I understand and agree to the policy. I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient to AMH. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of AMH's right to require payment directly from the undersigned. AMH expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several. All deductibles and co-pays are due at the time of service. We accept cash, checks, or Visa/Master cards.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below you acknowledge receipt and opportunity to review AMH Healthcare Privacy Policy Notice and consent to sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment and Payment agreement.

I understand and agree to the above statements.

_______________________________ ___________ X__________________________________ __________

Patient name Birth Date **Signature** of Patient/Parent/Guardian Date

(**IF signed** acknowledgement, **SKIP to page 2**)

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on __________. The acknowledgement was not obtained because:____

Name of Staff Member_________________________ **Signature** of Staff Member __________________________ Date___________

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Authorization to Leave Message

In completing and signing this form, I authorize that Advanced Mobile Healthcare may leave a message containing medical information for a period of 12 months from the date signed on this form and as follows:

- ☐ On my home voice mail/answering machine. ☐ Yes ☐ No ☐ N/A
- ☐ On my cell phone voice mail #______________________. ☐ Yes ☐ No ☐ N/A

Designated Personal Representatives

In the space below, if so desired, please indicate any personal representatives(s) (i.e. any family member, friend, or individual) who is permitted to receive or know personal health information concerning your health care for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact AMH in writing and request the change.

☐ I designate personal representatives as follows:

____

Name relationship phone

____

Name relationship phone

____

Name relationship phone

____

Name relationship phone

If you would like to change any of the information on this form, prior to the end of the time period stated above, you must contact AMH in writing and request the change. This form must be up-to-date, signed and on file in your chart prior to any medical information being left on answering machines or with individuals you designate.

______________________________ ___________ X_________________________________ __________

Patient name Birth date Signature of Patient/Parent/Guardian Date