AMB HEALTHTIPS & HOUSECALLS, INC.

CONSENT AND FINANCIAL POLICY

This consent is required by HIPAA, Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:
I, with my signature, authorize ***AMB Healthtips & HouseCalls, INC*** and any employee working under the direction of the provider to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Financial Policy:
We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/ responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all payments at the time of service.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care. I have read and understand the Consents and Financial Policy stated above and agrees to accept full responsibility as described above

Patient/Responsible Party ______________________ Date: ______________________

Patient name if different from Responsible Party: ______________________