MD24 House Call
PERSONALIZED MEDICAL CARE

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to **MD24Housecall**, providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in **MD24Housecall** practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medications reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. **MD24Housecall** will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.
*When providing CCM Services, **MD24Housecall** must:*

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgement and Authorization
By signing this Agreement, you agree to the following:

- You consent to **MD24Housecall** providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a protion of CCM Services even through CCM Services will not involve a face-to-face meeting with the provider.

Beneficiary Rights.
You have the following rights with respect to CCM Services:

- **MD24Housecall** will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking the Agreement effective at the end of the then-current month. You may revoke this agreement in writing (14780 W Mountain View Blvd. 110 Surprise , AZ 85374). Upon receipt of your revocation, **MD24Housecall** will give you written confirmation (including the effective date) of revocation.

Signature:_____
Print Name:_____
Date:_____

MD24 House Call
A RETURN TO TRADITIONAL MEDICINE...

CONSENT FORM

Today's Date _____ Patient Consent Form For: _____

CONSENT FOR TREATMENT: I recognize that I need medical services. I voluntarily consent to treatment by the medical staff of MD24 Inc., as deemed necessary in their judgement. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests. I understand that if major diagnostic studies or treatment procedures (such as surgery) are required, I will be asked to give specific consent for those events.

USE OF MEDICAL INFORMATION: I understand that, consistent with Arizona state and federal laws, MD24 Inc. will share all medical information as necessary for continuation of care and with any other institution or person as permitted by law. As an example, I understand that MD24 Inc. does not have an in-house laboratory and uses an outsourced medical lab, and my lab work and personal information is shared to accomplish testing as required or requested. Privacy and confidentiality of personal health information is important at MD24 Inc. There are policies in place to insure that your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves the office either electronically, by facsimile, or paper record without specific authorization by the patient.

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to MD24, Inc.

I have read and fully understand, to my satisfaction, this entire document consisting of consent to treat and use of medical information. I may be asked to update my signatures and personal information annually or not less than once every three years. I am capable of signing this document on my own.

ATTESTATION: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MD24, Inc. or insurance company to release any information required to process my claims.

Patient Signature _____ Date _____

ATTESTATION: I AM the Legal Medical Power of Attorney that will be informed of all medical decisions and visits: POA

Name _____ Cell Phone _____

Home Phone _____ E-Mail Address _____

Address _____

Power of Attorney Signature _____ Date _____

NOTE: *We require the patient's legal Power of Attorney to sign all new patient consent forms prior to treatment. In urgent cases we will attempt to contact the patient's POA by phone and fax documents if necessary; however we must have an original, hand written signature on file. Please sign this form and return the original to:* **MD24, Inc. 14780 W. Mountain View Blvd., Suite 110, Surprise, AZ 85374**

This form meets the consent requirements for on-site and telemedicine coverage.

MD24 House Call
A RETURN TO TRADITIONAL MEDICINE...

Medical Records Release Authorization

I, _____ hereby authorize the release of my medical records to MD24 House Call physicians. MD24 Inc. requests only the following pertinent and succinct medical record information to be forwarded from other medical and health care providers:

1. Problem Lists
2. Vaccination History
3. Past and Current Medical History
4. Past Surgical History
5. Current Medications and Past Pertinent Medications
6. Social History
7. Allergic History
8. Recent Physical Exam
9. Pertinent and Recent Laboratory and Radiology Tests
10. Additional pertinent information at the health care provider's discretion

Notice of Privacy Practices

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), MD24 Inc. will keep all of your health information confidential.

Note that for the purposes of medical treatment (e.g. medicating prescriptions, discussing your case with a consulting physician), payment (e.g. insurance paperwork which shows your diagnosis and corresponding diagnostic codes), health care operations (e.g. self auditing our medical records, quality improvement), and medico-legal considerations (e.g. medical examiners, law enforcement officials, public health authorities), your health information may be obtained or disclosed by telephone, e-mail, mail, or facsimile.

Patient Name _____

Patient Phone _____

Patient Date of Birth _____

Patient Address _____

My signature below indicates that I authorize medical record release to MD24 Inc.

Patient or Guardian Signature _____

Date and Time _____