PATIENT CARE CONSENTS AND AUTHORIZATIONS

Abode Care Partners, a company of licensed physicians, nurse practitioners, other professionals, along with independent third-party collaborative partners, offer medical services to patients in their respective place of service.

Consent to Medical Treatment & Assignment of Benefits

I, _____(Patient), give permission to Abode Care Partners (ACP) to give patient medical treatment including but not limited to exams, diagnostic tests, and medication. I understand that Patient will be cared for in accordance with the plan that Patient's physician(s) deem appropriate, and that I have the right to revoke this consent and/or refuse medical treatment for Patient at any time. I authorize ACP to bill Patient's insurance for medical services provided to Patient, which ACP is authorized to bill. I authorize release of medical information necessary to process all medical insurance claims. I understand that I must pay my share of costs for the care I receive such as co-payments or deductibles, or if I do not have insurance.

Chronic Care Management (CCM), Behavioral Health Integration (BHI), and Remote Patient Monitoring (RPM) Services:

ACP provides services to help manage ongoing chronic health conditions and/or behavioral health. These services include access to a care team, comprehensive electronic plans of care, management of transitions and other care management services which can include sharing health information with other providers. I understand that only one provider can furnish and bill CCM services during the calendar month. As with other medical services there may be cost sharing responsibilities such as co-payments or deductibles. I understand that Patient has the right to stop services at any time by notifying a member of the ACP team.

☐ I consent to receive these services, if needed.

Telehealth Services

I understand that certain services are offered via telehealth and that anyone virtually or physically present during a telehealth service with Patient may receive Patient's personal health information. I understand that Patient can stop using telehealth services at any time by notifying a member of the ACP team.

☐ I consent for Patient to participate in and receive medical care through Telehealth.

Electronic Communication

ACP may communicate with patients about their care using email or text messaging. These communications may not be secure and could be assessed by unauthorized third parties.

☐ I consent to receive electronic communications about my medical care from ACP.

I agree to receive services as set forth above: _____ Date: _____
(Signature of Patient or Legal Representative)

If Legal Representative: _____ Relationship to Patient: _____
(Printed Name)