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.

Care Management Services

ACP provides services to help manage ongoing chronic health conditions. These services may include Chronic Care Management (CCM), Remote Patient Monitoring, and Advanced Primary Care Management (APCM). 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/APCM 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.

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.

Advanced Dictation

I understand that during my visits, my healthcare provider will use advanced dictation (artificial intelligence and ambient scribing) tools to assist with documenting my medical information. This advanced dictation technology will capture and analyze our conversation to generate clinical notes, which the provider will review and edit before adding to my medical record. I consent to the use of this advanced dictation tool and understand that my personal health information will be handled securely.

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.

CONSENT FOR SERVICE EVALUATION: ACP offers a free evaluation of eligibility for additional/related home healthcare services by our providers and our affiliates that may benefit your health and safety in your home, as well as follow-up regarding satisfaction with services rendered and to ensure our patients have maintained their health and wellness following discharge. By granting your consent, you understand that if you are eligible for new or additional services you can have a choice of provider, should you choose to accept any additional services. This Services Evaluation Consent expressly authorizes contact to include, but not be limited to, telephone calls, emails, and/or text messages (as indicated below). You may opt out of these communications at any time. Please note that messaging and data rates may apply. Your response to this Services Evaluation Consent will not affect your ability to receive care from ACP.

☐ I consent to be contacted by email at _____ and/or by telephone or text message at _____ about additional and/or related healthcare services offered by ACP and its affiliates.

☐ I do not consent to the complimentary services evaluation.

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

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