Physician House Calls
An Affiliate of Kindred House Calls

Authorization to Bill

10900 W. 44th Ave, Suite 200
Wheat Ridge, CO 80033

PLEASE SIGN AND RETURN

We are a Medicare Participating Provider

My signature and date below authorizes/acknowledges each of the following:

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf, including billing of Chronic Care Management services (CCM) as outlined in the Practice Policies document which I have received.

2. Release of my medical information to my insurance providers and their agents.

3. Physician House Calls and/or any of their corporate affiliates to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

4. I acknowledge that I have received a copy of Physician House Calls's Notice of Privacy Practices.

5. There are certain services Physician House Calls provides which are not covered by Medicare and most other insurances. These charges must be paid by the patient or their representative at the time of service. The following charges may apply:
   - Missed Visit Fee **$75**
   - Formal Letter Requests **$40**
   - Records (free to MD office) **$35**
   - Care Plan Oversight (other than Medicare) **$40**
   - Long Term Care Form **$40**

SIGN, DATE AND RETURN THIS PAGE IMMEDIATELY! In order for us to bill Medicare and/or other insurance for your medical supplies and/or medications, this page must be completed, signed, dated and returned immediately.

Name of patient/legal representative: _____

Relationship to patient: _____

SIGNATURE: X_____

Date: _____

Authorization To Release Protected Health Information

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Patient Information - please fill out completely	
Patient Name:	
Address:	
City/State/Zip:	Phone Number
Date of Birth: / /	

I hereby authorize the following provider to disclose the above-named individual's health information. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Name of Facility Releasing Information:

Provider to whom information will be released:	**Purpose of disclosure:**
Physician House Calls 10900 West 44th Avenue, #200 Wheat Ridge, CO 80033 Please FAX requested information to (303)284-4082 or mail to the above address	TREATMENT

Information to be used/disclosed:		
Progress notes	Laboratory reports	
Consultations	Radiology/Imaging reports	
Most recent history and physical	Radiology films	
Immunization record	Two-way verbal exchange of communication	
Other:	Entire medical record	
Date Range of Information Disclosed	Start Date / /	End date / /

By signing this authorization, I agree to the following:

- I understand if I authorize my information to be released to persons or organizations not subject to federal privacy laws, the information may be re-disclosed by the recipient and the information will no longer be protected.
- I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization at any time by contacting my provider, but any revocation will not apply to the extent that my provider has acted in reliance of this authorization.
- I authorize the use and disclosure of my health information as described above. This authorization expires one year from the date on which it was signed, unless otherwise specified. (Otherwise specified date, event, or condition: _____)

X

_____ _____

Signature of Patient or Personal Representative Date

_____

If not signed by patient, list personal representative's authority to act for the patient