Phone: 480-575-0576 **Fax: 480-575-0512**

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Assignment of Benefits

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare and/or Medicaid (Ahcccs) insurance benefits to Joel Cohen, MD, Medical Director of MD RoomService/DoctorCare, PLLC. (PO Box 7904, Cave Creek, AZ 85327)
2. Direct billing to Medicare and/or Medicaid (Ahcccs) – **electronically** or on paper claim forms.
3. Release of my medical information to Medicare and/or Medicaid (Ahcccs).
4. Dr. Joel Cohen may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments and deductibles.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare and/or Medicaid (Ahcccs) to issue payment check(s) directly to Dr. Joel Cohen for medical services rendered to myself and/or my dependents. **I understand that I am responsible for any amount not covered by insurance**.

Authorization to Release Information
I hereby authorize Dr. Joel Cohen to: (1) Release any information necessary to insurance carriers regarding my illness and treatments; (2) Process insurance claims generated in the course of examination or treatment; and (3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Joel Cohen on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature: **Date:**

____ _______________

PO Box 7904
Cave Creek, AZ 85327
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Fri: 9am-12pm

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Medical Records Release Form

Patient Name_________________________________ Birth Date_____________

Address____

City______________________________ State____________ Zip___________

Home Phone________________ Business Ph______________ Cell____________

Records Release Authorization

By my signature, I authorize **DoctorCare** to receive my pertinent medical records for the patient identified by the information listed above.

Medical Records Requested

For the past 18 months:

Radiology (Xray, Ultrasound, CAT Scan, MRI, Special tests) Reports, EKG, Specialist Consults, Hospitalization Summaries, Labs, Updated Medication List.

I authorize the release of photocopies of the following medical records to DoctorCare, its employees, and/or agents. For the purpose hereof, “Medical Records” includes the following:
Confidential HIV and communicable disease-related information (A.R.S. Section 36-661)
Confidential Alcohol & Drug Abuse-related information (42 CFR Section 2.1 ET SEQ)
Confidential Mental Health Diagnosis/Treatment Information
Confidential Genetic Testing Information (A.R.S. Section 12-2801)

I have given my consent freely and without coercion. I may revoke this consent at any time by notifying DoctorCare in writing. A photocopy or Facsimile of this authorization can substitute for the original.
MAIL RECORDS TO: PO Box listed at top of consent form

____ ____________________

Patient/Authorized Signature **Date**

Phone: 480-575-0576 **Fax: 480-575-0512**

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HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.
As our patient we want you to know that we respect the privacy of your personal medical data and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.
We support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.
You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please speak with Dr. Cohen.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Internet Medical Record Storage

I, the undersigned, hereby authorize the medical office of Joel Cohen, M.D., including but not limited to Dr. Cohen, his staff and his agents, to store medical and required related information about me on a secure off-site server. Communication of this medical sensitive and related non medical data will be done with encrypted transfer over lines (i.e., wire, wireless or cable) on the Internet.
I understand that I must specifically advise Dr. Cohen in writing if I do not want certain information about me stored in this manner.
Through this authorization, I am hereby irrevocably releasing the medical office of Joel Cohen, M.D. including but not limited to Dr. Cohen, his staff and his agents, from any and all liability for any damages or costs, or both, relating to or arising out of the storage of my medical records in this manner.
This authorization shall remain in effect until I specifically notify Dr. Cohen in writing that I no longer want medical information about me stored in this manner

Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of, and provide individuals with the notice of our legal duties and privacy respect to protected health information. If, after having read the HIPAA Notice of Privacy Practices, you have any objections to that form, please as to speak with our HIPAA Compliance Officer in person or by phone at the main office number.

Your signature below is an acknowledgement that you have received the Notice of our Privacy Practices.

__________________________________ __________________________________

Patient Name (Please Print) **Patient Signature**

Phone: 480-575-0576 **Fax: 480-575-0512**

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Credit Card Payment Consent Form for Medicare and private-pay patients only

Because of difficulties contacting POA's or relatives when payment is due, **we require a credit card number** on file to charge for payment balances. Many secondary insurers do **not** automatically crossover after Medicare payment is approved. Occasionally, secondary insurers will consider house calls a "non-covered" charge.

I understand that **DoctorCare will charge my credit card** for unpaid balances for Home Visits. These unpaid amounts may include:
1. Unpaid 20% (by secondary insurer) if Medicare pays 80%; or No secondary coverage
2. Medicare denials that cannot be quickly resolved.
3. Annual Deductibles for Primary or Secondary insurer.
4. Secondary insurers that do not automatically cross-over from Medicare: It is the **patient's (POA) responsibility** to get reimbursed the 20% from these insurers.

A paid invoice can be mailed after credit card charges are completed, only **if requested** by patient or POA.

Any disputes regarding insurance coverage is the patient's or POA responsibility. DoctorCare does NOT dispute individual insurance coverage with insurance companies. **Payment for house calls is the responsibility of the patient or POA**.
Thank you in advance for your understanding so we can continue to provide this valuable medical service.

Patient Name ____

Name on Card____

Address ____

Phone Number ____

Credit Card: Visa Mastercard AMEX Discover

Credit Card # ____**Expiration**__________

Patient or POA **signature**____
(Required)

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Date: ____________ ***Please print legibly***

Patient name ____
(Last) *(First)* *(MI)*

Address: ____
(where patient is currently residing) (Street) (City)

__________ __________ ***Name of Assisted Living Facility*** ______________________
(State) (Zip Code)

Home Phone: ____________________ ***Cell phone:*** ____________________

Email Address:____________________ FAX:____________________

Patient Social Security ____________________ **Date of birth**____________________

Is Patient (please circle): *Male* *Female* **Marital Status:** *Married* *Single* *Widowed*

Emergency Contact/POA: ____
(Last Name) (First Name)

Billing Address: ____
(Street) (City)

__________ __________**Phone:**________________________________
(State) (Zip Code) (best way to contact)

Primary Insurance:____________________ **ID#**____________________

Secondary Insurance:____________________**ID#**____________________

Medicare ID#: ____________________

Case Manager:____________________**Phone:** ________________ **Fax**:________________

Pharmacy Name:____________________ **Phone:**____________________

Fax:____________________

	(circle)	
Is there a Living Will or	**YES**	**NO**
Advance Directive	**YES**	**NO** *(copies available on our website)*
DNR (do not resuscitate)	**YES**	**NO**
Hospitalize in Emergencies	**YES**	**NO**
Is patient on Oxygen	**YES**	**NO**
Is patient bedridden	**YES**	**NO**
In wheelchair	**YES**	**NO**
Drive Scooter	**YES**	**NO**

Patient approx. weight: ______________
Patient approx. height: ______________

Date of last known Pneumovax (Flue) shot:________________________________

Any known allergies?________________________________

Patient's current diagnosis ________________________________

Please list names and phone numbers of prior doctors or hospitals from whom we may request records:

____

____

PLEASE INCLUDE COPIES OF ALL INSURANCE CARDS, FRONT AND BACK, THANK YOU!