Phone: (561) 215-7151
Fax: (717) 674-4067
cbrooks@mobilehcs.com

Authorization to Treat, Bill & Acknowledgment of Privacy Practices

I voluntarily request and consent to treatment with Mobile Healthcare Solutions, LLC. I authorize Mobile Healthcare Solutions, LLC, including physicians and advanced practice providers to conduct treatment related to my care.

If eligible, I authorize Mobile Healthcare Solutions, LLC to serve as my chronic care management and/or transitional care management services and share my health information with providers as needed for my care coordination. Mobile Healthcare Solutions, LLC has explained chronic care management and transitional care management to me and that only one provider at a time may provide these services each calendar month. I understand how to access these services and how to terminate these services if needed. I understand that I will be responsible for any associated copayment or deductible associated with chronic care management or transitional care services.

I authorize the submission of a claim for payment to Medicare, Medicaid or any other payor for any services provided to me by Mobile Healthcare Solutions, LLC. I understand that I am financially responsible for the services and supplies provided to me by Mobile Healthcare Solutions, LLC regardless of my insurance coverage and, in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Mobile Healthcare Solutions, LLC any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Mobile Healthcare Solutions, LLC. I authorize Mobile Healthcare Solutions, LLC to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to Mobile Healthcare Solutions, LLC and its billing agents, the Center for Medicare & Medicaid Services and/or any other payors or insurers and their respective agents or contractors as may be necessary to determine these or other benefits payable for any services provided to me by Mobile Healthcare Solutions, LLC.

By signing below, I hereby acknowledge Authorization to Treat and Bill accordingly.

Name: ____________________________ Date of birth: ___________________________________

Signature: ____________________________ Date: ____

By signing below, I hereby acknowledge Receipt of the Notice of Privacy Practices.

Signature: ____________________________ Date: ____

If signed by someone other than patient, relationship to patient:

Name: ____________________________ Relationship: ___________________________________

Reason why patient cannot sign: ____

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