

341 Allison Drive. Palm Bay, FL 32908

Phone (321)282-1499 Fax (321)256-6212

**CONSENT TO TREAT PSYCHIATRIC CONDITIONS, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT RESPONSIBILITY**

**CONSENT TO MEDICAL TREATMENT**  The undersigned voluntarily gives consent to Glomar Medical Inc., and all providers associated with the practice, to medical treatment of psychological disorders as may be deemed necessary or advisable in the judgment of the provider. The undersigned is aware that the practice of medicine is not an exact science, and acknowledges that no guarantees have been made as to the result of treatments or examinations.

**AUTHORIZATION TO RELEASE INFORMATION**  In consideration of services rendered, the undersigned hereby authorizes Glomar Medical Inc. the ability to disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the practices charge, including but not limited to medical service companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.)

**FINANCIAL AGREEMENT**  The undersigned agrees, whether he / she signs as an agent or as patient, obligates himself / herself to pay the account of the medical practice in accordance with the regular rates and terms of the medical practice. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney fees and collection expenses. Undersigned certifies that he / she has read the foregoing, receiving a copy of thereof, and is the patient or is duly authorized by the patient as the general agent to execute the above and accept its terms.

**MEDICARE / MEDICAID**  The undersigned certifies that the information given to Glomar Medical Inc., in applying for payment under Title XVII/XIX of the Social Security Act, is it correct and Glomar Medical Inc, may release this information to the Social Security Administration Division of Family Services or intermediaries or carriers any information needed or related to submit at Medicare / Medicaid Claim.

**PAYMENT RESPONSIBILITY**  The undersigned hereby certifies all Insurance pertaining to treatment shall be assigned to Glomar Medical Inc., and understands that if an insurance claim is denied for any reason, the undersigned or authorized representative is responsible for payment in full. The undersigned also understands the responsibility and agrees to pay any  **CO-PAY, DEDUCTIBLE, COINSURANCE, OR**

**ANY OTHER BALANCE NOT PAID BY INSURANCE OR THIRD-PARTY PAYER WITHIN A**

**REASONABLE TIME NOT TO EXCEED 60 DAYS.**  The undersigned agrees to provide valid credit card information to be kept on file, and agrees to allow Glomar Medical Inc., to automatically bill the credit card on file any and all unpaid or outstanding balances owed to the practice after 60 days from date of service; unless a prior agreement has been made

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZED REPRESENTATIVE (IF NOT THE PATIENT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# RELEASE OF RECORDS

I do hereby agree to disclose protected health information as follows:

**Patient’s name** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of authorized representative if not the patient:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-This information will be used for continuity of medical care

-This authorization will be kept on file and does not expire unless explicitly revoked in writing or upon discharge from the practice. I understand that the written revocation will not apply to information that has already been released in response to this authorization. I understand that my revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy

❏ I do hereby agree to allow  **Glomar Medical Inc.,**  to receive and disclose the following health information:

Address: 341 Allison Dr., Palm Bay, Florida 32908

Phone: (321)282-1499 Fax: (321)256-6212

* Entire medical record
* Laboratory reports
* Pathology reports
* Diagnostic Imaging reports
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ I do hereby agree to allow  **Glomar Medical Inc.,**  to receive and disclose the following health information:

Address: 341 Allison Dr., Palm Bay, Florida 32908

Phone: (321)282-1499 Fax: (321)256-6212

* Mental health information
* Genetic testing information ● Drug/Alcohol diagnostic information

**Patient or authorized representative signature** :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**PATIENT INTAKE FORM**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Male or Female: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact / Power of Attorney or person who handles patient affairs:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_**

**Secondary Insurance Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_**

# Do Not Resuscitate (DNR)? No Yes (circle one) Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

**As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and**

**Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU**

**MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.**

**Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.**

**Treatment: We will use and disclose your protected health information to provide, coordinate, or manage**

**your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.**

**Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.**

**Healthcare Operations: We may use or disclose, as‐needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal**

**Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation.**

**Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.**

**Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose**

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**any part of your protected health information for the purposes of treatment, payment or healthcare operations.**

**HIPAA NOTICE OF PRIVACY PRACTICES CONT.**

**You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

**We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.**

**Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.**

**Your signature indicates that you have read and agree with the HIPAA statement above. A copy of this HIPAA statement will be provided to you upon your request.**

**Patient or authorized representative signature** :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Chronic Care Management Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow GLOMAR MEDICAL Inc. to provide chronic care management services to you.

CCM services are only available to patients with two or more chronic conditions.

Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services include: 24/7 access to a care provider to help with your chronic healthcare needs A comprehensive plan of care for health needs, available on paper or electronically Coordination with both home and community-based service providers Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities Medication oversight and management

By signing this agreement, you consent to allow GLOMAR MEDICAL to provide CCM services to you. You certify that you understand the scope of CCM services to you. You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month. You authorize electronic communication of your medical information between treating providers as part of your care. You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services. You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying GLOMAR MEDICAL by telephone at: (321) 282-1499, or by mailing your written revocation to: *info@glomarmedical.com*

Beneficiary/Responsible Party Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 12/21