PHA
ADULT MEDICINE
DELIVERING THE CARE YOU NEED
Text PHA to 55469

1740 South Street, Suite 300, Philadelphia, PA 19146
TEL: 215-732-0876
FAX: 215-732-1812
WEBSITE: www.phaadultmedicine.com
Download: Healow App for Patient Portal

FORM 1: CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information

I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Philadelphia Health Associates-Adult Medicine (PHA) to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay Philadelphia Health Associates-Adult Medicine directly, I agree to forward to PHA all health insurance payments which I receive for the services rendered by PHA and its health care providers. I authorize PHA any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate with PHA, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided by PHA and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to not obtain services prior to prior-approval by my insurance. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment

As a PHA patient, I voluntarily consent to the rendering of such care and treatment as PHA providers and personnel, in their professional judgment, deem necessary for my health and well-being. **If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its documentation and I understand I may terminate such visit at any time. I also understand that telehealth visit is billable with applicable co-pays and deductible. I also understand that telehealth visits have limitations compared to face-to-face in-person visits. Telehealth visits require me to be web-enabled at the office. I need a cell phone with audio/visual (face-time) capability to have a telehealth visit.** My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing, draining of skin abscesses), vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by staff involved in my care. I acknowledge that because medicine is not an exact science, no guarantees or warranties can be made to me regarding any results of any diagnostic procedures or medical treatments performed at Philadelphia Health Associates-Adult Medicine, PC.

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Consent to Call, Email & Text

I understand and agree that PHA may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. To facilitate communication and get access to my records, I will activate an account through the Patient Portal which I can access at www.phaadultmedicine.com or download HEALOW APP to my smartphone. Patient Portal activation requires an email address. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from PHA. I understand that I may optout of receiving such communications from PHA by writing letter to office, calling the office or sending message via Patient Portal.

HIPAA.

I understand that PHA's Notice of Privacy is available at www.phaadultmedicine.com and that I may also request a paper copy at the reception desk. I hereby acknowledge that I have received I have read Payment Policy and PHA's Notice of Privacy Practices. I agree to the terms of the Payment Policy, the sharing of my information via HIE (Health Information Exchange), and consent to my treatment by PHA providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with PHA providers. The Health Information Exchange allows PHA and external institutions such as hospitals and other providers to share information to better coordinate care of mutual patients.

I realize that I have the right to refuse any drugs, treatments or procedures to the extent permitted by law.

External Prescription History

I understand that it is important for my healthcare provider to be aware of all medications that I am taking. Such knowledge will reduce incidences of drug interactions and other side effects that may occur from taking multiple drugs. If possible, I am giving permission for my health care provider to view prescription history from outside sources**.**

I initial here to provide consent. _____. Refusal can result in inability to be prescribed certain medications including but not limited to controlled substances.

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Attestation

I acknowledge that I understand the above and any questions I may have had were answered to my satisfaction. **I understand that a photocopy or electronically stored copy of this signed document is as valid as the original.**

Patient/Guardian/Surrogate Decision Maker:

Email: _____
Signature: _____
Date: _____