advocare

Annual Consent and Acknowledgment Form

This form is to be completed annually for Advocare LLC and scanned into each Patient's File

Patient Name: _____ DOB: _____

Address: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

Advocare and its parent, affiliates, associates, agents, services, debt collectors, independent contractors, assigns, successors, subsidiaries and employees (defined here collectively as "ADVOCARE" and referred to as "ADVOCARE" or "we") provide healthcare services (referred to collectively as the "Services"). By using the Services or accessing your account, any recipient of the Services accepts and also agrees to be legally bound by the terms of this Agreement to the extent permitted by law.

General Consent for Examination and Treatment

I hereby consent and authorize Advocare and all its physicians and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. This consent includes consent and authorization to photograph or otherwise take images of me for purposes of identification, diagnosis, treatment, payment and healthcare operations. Any photographs or other images taken will become part of my medical record. Advocare will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advocare will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have been offered a copy of Advocare's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advocare has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, Advocare will post a new notice in its offices. I may contact Advocare at any time to obtain a current copy of the Notice of Privacy Practices. I may also access a copy on the Advocare website at www.advocaredoctors.com

Assignment of Benefits/Authorization/Notice of Collection

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles and charges denied by my insurance company as not covered or not medically necessary. You agree to reimburse Advocare the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt added to the debt at the time it is placed with the agency for collection, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Consent to Contact

You expressly authorize, and specifically consent to allowing, ADVOCARE and/or its outside collection agencies, outside counsel, or any other agents acting by or on behalf of ADVOCARE to contact you or any recipient of the Services with informational messages regarding your account, including but not limited to contact in connection with any and all matters relating to unpaid past due charges billed to you. You agree that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that you or a recipient of the Services have provided, or may in the future provide, to ADVOCARE and to any and all telephone numbers billed on your account or any number where you or a recipient of the Services can be reached by ADVOCARE. You expressly consent and agree that such contact may be made using, among other methods, pre-recorded, artificial voice, or other message delivered by any type of telephone equipment including a dialer, automatic telephone dialing system, predictive dialer, interactive voice recognition system, or text message delivered by an automated system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system, including numbers assigned to any paging, cellular or mobile service, even for any service for which you are charged for the call or contact. Carrier message and data rates may apply. You agree to provide true, accurate, current and complete contact information about yourself and any recipient of the Services to ADVOCARE and its authorized agents and to promptly update this contact information to keep it true, accurate and complete. If you do not want ADVOCARE to use these telephone contact methods to reach you or a recipient of the Services, please contact us at 856.221.2700 to discuss how we may communicate about this account

Vaccine Registry (if applicable)

Our office submits confidential data of children and adult vaccinations to your state's Immunization Registry as permitted by state law. The purpose of this registry is to keep a central record of patients' immunization history.

Disclosures to Authorized Individuals

I designate the following person(s) listed below as a person(s) involved with my medical treatment and/or payment for my medical treatment. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. A copy of the authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No Payment Information: Yes No

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical Treatment Information: Yes No Payment Information: Yes No

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

Consent and Authorization

A copy of this consent and acknowledgment may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my PHI and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Legal Representative (if other than patient) Print Name: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____