CONSENT FOR MEDICAL SERVICES AT HOME

Consent is given to the physicians providing medical services on behalf of Lotus Primary and Palliative Care to provide medical services to _____ in Patient's home. Medical services shall include all treatment and other procedures ordered by the patient's physician. The medical condition(s) of the patient has been explained to me by a physician to my satisfaction.

I acknowledge that in the course of a patient's care, a patient's physician may elect to use a variety of medically necessary procedures and tools including, but not limited to, diagnostic testing, blood work, wound care and injections.

Possible alternative treatments and procedures and the potential risks of the proposed treatment(s) or procedure(s) and alternatives have been explained to me.

I understand that one of the tests that may be performed is a test to find out whether the human immunodeficiency virus (HIV), the virus that causes AIDS, is present in the patient's blood. This test may be performed if the Patient's treatment is to include any breaking of the skin or other invasive procedure. I consent to this test in these situations. In addition, I understand that blood may be drawn from the patient for testing for HIV without further permission being given by me or anyone else if a doctor, other health professional or Lotus Primary and Palliative Care employee is exposed to the blood or body fluids of the patient.

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge and agree that no guarantees have been made by Lotus Primary and Palliative Care, providers providing services on its behalf or other employees of Lotus Primary and Palliative Care as to the results of the care and treatment authorized.

I acknowledge that the Patient's physician, or his or her associate(s) is overseeing and responsible for the performance of the procedure(s) or treatment(s) listed above, and any other procedure(s) or treatment(s) required by the Patient's medical condition.

I understand that the services and care of nurses, technicians, assistants and other personnel providing care on behalf of Lotus Primary and Palliative Care may be required, and I authorize such personnel to provide service and care.

I acknowledge and understand that Lotus Primary and Palliative Care does not provide emergency care or care for life-threatening emergency medical conditions.

Should they qualify, I consent to Lotus Primary and Palliative Care providers providing chronic care management services to help in management of the patient's pre-existing chronic conditions (2 or more chronic conditions which are expected to last at least 12 months and which place you at significant risk for further decline). Further, I understand that at any time I may request Lotus Primary and Palliative Care cease to provide me with this service. I authorize Lotus Primary and Palliative Care representatives to send HIPAA compliant electronic communication of Pa ent medical information to other treating providers as part of coordination of the Patient's care. The undersigned Patient or legal authorized representative ("Agent") of the Patient acknowledges that they personally received a copy of the Lotus Primary and Palliative Care Notice of Privacy Practices

I consent to the release of requested medical records and any other information to appropriate insurance carriers or other third parties who may pay for the Patient's care, including records indicating testing, diagnosis or treatment of HIV infection, AIDS or any related condition. I give consent to the release of information to physicians or other persons when such information may benefit the patient.

Chronic Care Management
I agree to participate in chronic care management. I understand that there may be a copay. I understand I cancel chronic care management at any time. I understand that chronic care management includes sharing my information with other medical providers. I understand that only one practitioner can bill for chronic care management.

Remote Patient Monitoring
You may benefit from Remote Patient Monitoring. Through devices provided by Accuhealth, we will be able to remotely monitor your vital signs and other data in order to ensure compliance with treatment regimens and have real time discussions with you when your vital signs are off base. Signing gives your consent to enroll you in the Remote Patient Monitoring program and receive Remote Patient Monitoring services from me, in conjunction with Accuhealth. As a condition of receiving Remote Patient Monitoring services, I will provide your home telephone number, cell number and email address to Accuhealth. The Terms of Use for the Remote Patient Monitoring services will be included in your welcome box. Please review this document carefully. By using the Accuhealth Service, you are agreeing to be bound by the Terms of Use document that will be included in your welcome box. If you decide not to receive Remote Patient Monitoring services at any time, you can contact me.

Payment for Services Rendered
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare), Blue Cross, Title XIX (Medicaid) and any other insurance program is correct. (I request that payment of authorized benefits be made on my behalf.)

I understand that Lotus Primary and Palliative Care will bill third party health insurance carriers or government programs for services rendered, according to information I have supplied, and agree that Transitions Geriatrics Group may bill me and expect payment for any unpaid balance on the account, depending on the terms of the insurance covering Patient.

I accept full responsibility for all charges incurred or to be incurred in the treatment.

By signing this form I am stating that I have read it, understand it and agree with what it says. All questions I have asked about this form and its meaning have been answered to my satisfaction.

_____

Patient's Name (Print) Signature (☐ patient, ☐ patient's relative, or ☐ legal guardian) Date