CONSENT FORM

CONSENT FOR TREATMENT:

I recognize that I need medical services. I voluntarily consent to treatment by the medical staff of the practice, as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests. I understand that if major diagnostic studies or treatment procedures (such as surgery) are required, I will be asked to give specific consent for those events.

USE OF MEDICAL INFORMATION AND NOTICE OF PRIVACY PRACTICES:

I understand that, consistent with Arizona state and federal laws, SIP Home Systems LLC (DBA "SIPMD"), successors and assigns, (referred to as "Provider" from here on) will share all medical information as necessary for continuation of care and with any other institution or person as permitted by law. As an example, I understand that Provider does not have an in-house laboratory and uses an outsourced medical lab, and my lab work and personal information is shared to accomplish testing as required or requested. In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Provider will keep all of your health information confidential. Note that for the purposes of medical treatment (e.g. prescriptions, discussing your case with a consulting physician), payment (e.g. insurance paperwork which shows your diagnosis and corresponding diagnostic codes), health care operations (e.g. self auditing our medical records, quality improvement), and medico-legal considerations (e.g. medical examiners, law enforcement officials, public health authorities), your health information may be obtained or disclosed by telephone, e-mail, mail, or facsimile. The Practice may incorporate the limited summary of my health record it receives through State Health Information Exchange - HealthCurrent into the Practice's own clinical record. From then on the Practice may further disclose such information only in accordance with the rules that apply to it as a covered provider under HIPAA and 42 CFR Part 2.

I acknowledge that I have been provided with Provider' Notice of Privacy Practices. A copy of the Notice is available on our website; www.sipmd.com

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to Provider. I have read and fully understand, to my satisfaction, this entire document consisting of consent to treat and use of medical information. I may be asked to update my signatures and personal information annually or not less than once every three years. I am capable of signing this document on my own.

ATTESTATION:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Provider or insurance company to release any information required to process my claims.

CONSENT FOR PAYMENT:

I hereby authorize payment of medical benefits billed to my insurance to Provider Physicians; I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Provider Physicians does not participate with my insurance. I hereby authorize Provider physicians to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operation.

MEDICAL AND MEDICATION RECORD RELEASE AUTHORIZATION:

I hereby authorize the release of my medical records to Provider. The Provider requests only the following pertinent and succinct medical record information to be forwarded from other medical and health care providers: 1. Problem Lists, 2. Vaccination History, 3. Past and Current Medical History, 4. Past Surgical History, 5. Current Medications and Past Pertinent Medications, 6. Social History, 7.Allergic History, 8. Recent Physical Exam, 10. Pertinent and Recent Laboratory and Radiology Tests, 11. Additional pertinent information at the health care provider's discretion.

I understand that while this consent is voluntary, if I refuse to sign this consent, Provider can refuse to treat me. I understand the authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any action that Provider takes before receiving my revocation.

This form meets the consent requirements for on-site and telemedicine coverage.

ATTESTATION:

I AM the Legal/Financial/ Medical Power of Attorney for Patient:_____ that will be informed of all medical decisions and visits:

POA Name	Cell Phone Number	Email Address
Address	**Current/ Former PCP Name**	**Current/ Former PCP Phone Number**

NOTE:

We require the patient's legal Power of Attorney to sign all new patient consent forms prior to treatment. In urgent cases we will attempt to contact the patient's POA by phone and fax documents if necessary; however we must have an original, hand written signature on file. Please sign this form and return the original to:* SIPMD *2375 E. Camelback Rd., Suite 600, Phoenix, Arizona 85016. Or Return By Fax to 480-712-0799

Patient		**Patient's Representative, or Patient's POA if applicable:**	
Signature:		Signature:	
Printed Name		Printed Name	
Date		Date	