ProHEALTH℠ Care

GENERAL CONSENT

Consent for Medical Treatment

I hereby consent to ProHEALTH Care Associates, LLP, including all of its divisions and clinical staff ("ProHEALTH") providing and performing such medical care, tests, procedures, and other services deemed necessary or beneficial for my health and wellbeing. I understand that to ensure quality and continuity of care, all ProHEALTH providers may have access to my electronic health record and will access same as necessary for my medical care.

Assignment of Insurance Benefits

I authorize payment to ProHEALTH of all monies and/or benefits to which I may be entitled from government programs, insurance carriers, or others who are financially responsible for the cost of my medical care and treatment. I hereby authorize the release of any and all medical records pertaining to me for the purposes of payment for the services rendered to me.

Financial Responsibility

I agree to pay all amounts for which I am responsible as a result of the services rendered to me, as further described on the Patient Responsibility Form. I understand and agree that ProHEALTH Medical Management, LLC may bill and/or collect payment on behalf of ProHEALTH.

Privacy and Self-Pay

I understand that my Protected Health Information (PHI) may be disclosed for purposes of treatment, payment, and healthcare operations and that I have the right to request a restriction of the uses and/or disclosures of my PHI. I further understand that in the event I request that a visit not be billed to my health insurance carrier, I will be financially responsible for that visit, and I must make payment in full.

Consent to Communication

By providing my telephone number to ProHEALTH on the Patient Registration Form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from ProHEALTH and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. By providing my e-mail address on the Patient Registration Form to ProHEALTH, I agree to receive e-mail messages from ProHEALTH and its affiliates. To stop receiving e-mails at any time, I may click "unsubscribe" at the bottom of the e-mail. ProHEALTH may send PHI to me, by text message or email, in an unencrypted manner. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

By signing below, I acknowledge that I have reviewed this form and understand its contents.

Patient's Name	Patient's Date of Birth
Signature of Patient or Legal Representative	Today's Date
Legal Representative's Name	Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Provider Notice of Privacy Practices.

Patient's Name	Patient's Date of Birth
Signature of Patient or Legal Representative	Date
Legal Representative's Name	Relationship to Patient

FOR OFFICE USE ONLY:

_____ Patient/Legal Representative refused to sign/accept Notice of Privacy Practices _____ Patient unable to sign

Healthcare Responsibilities Fact Sheet

Thank you for choosing ProHEALTH to support the healthcare needs for you and your family. We have outlined a standard review of what your healthcare responsibilities may include. ProHEALTH is dedicated to helping you navigate through your insurance coverage. Please review this information.

For any questions, please contact our Patient Billing Customer Service Unit

- Tel: 1-888-620-2685 / 516-622-6187
- Email: RCpatientrelations@prohealthcare.com

What are the differences between Co-Payment, Co-Insurance and Deductible?

Deductible: The amount you pay for covered healthcare services before your insurance plan starts to pay. For example, if an office visit costs $100.00 and your deductible is $1,000.00, you pay the full $100.00 for each visit until the $1,000.00 is met. This usually starts at the beginning of every year, but you should confirm with your insurance provider. Note: Deductible amounts vary from plan to plan, and you should contact yours for additional information.

Co-Payment: A fixed amount you pay for a covered healthcare service after you've paid your deductible. This varies based on whether you are seeing your primary care physician, a specialist or having surgery. Note: This also varies from health insurance carrier to carrier, and you should contact yours for additional information.

Co-Insurance: The percentage of costs of a covered healthcare service you pay after you've paid your deductible. For example if an office visit costs $100.00 and your co-insurance responsibility of $100.00 is 20%, then you are responsible for $20.00.

Review your benefits ahead of time by going on your insurance website or calling them. By doing this, you are prepared before your visit. In some instances, we understand that this is not possible and that is okay. Our goal is to be informative as much as possible. For example, if a deductible is not yet met, we won't be aware of the patient responsibility until the visit has been encountered. This then goes to our billing team to send out the charges to your insurance company.

Self-Pay: You do not have applicable insurance (health insurance, worker compensation, no fault insurance, etc.) to cover medical services rendered or you elect not to use insurance for this visit. You will need to notify the office if you choose not to use your insurance, and you will be given a form to complete.

Acknowledgement of Financial Responsibility

I, _____, agree to pay all amounts for services rendered that my insurance does not cover. I understand that I am responsible for my co-payment, and it must be paid at the time of service.

I understand that I am financially responsible for my health insurance deductible, coinsurance and non-covered service.

I understand that it is my responsibility to notify my doctor's office of changes to my name, address, insurance, employer and insurance card(s).

I understand that if my plan requires a referral, I must obtain it prior to my visit.

I understand that in the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I do not have active insurance coverage, I agree to pay for the medical services rendered to me at the time of service. I understand that I am entitled to receive an estimate of how much the visit will cost, and that the actual cost may differ from the estimate.

I understand that it is my responsibility to inform my Provider if this visit is for Worker's Compensation or No Fault Insurance

By signing below, I acknowledge that I have reviewed this form and understand its contents.

_____	_____
Patient's Name	Patient's Date of Birth
_____	_____
Signature of Patient or Legal Representative	Today's Date
_____	_____
Legal Representative's Name	Relationship to Patient