Putting HEALTH back in Healthcare!

AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:
I hereby voluntarily consent to outpatient care from A New Direction Health & Wellness, PLLC including; but not limited to routine diagnostic procedure(s), examination(s), and medical treatment(s), routine laboratory work and administration of medication(s) as prescribed by the nurse practitioner.
I further consent to the performance of those diagnostic procedure(s), examination(s), and rendering of medical treatment(s) by A New Direction Health & Wellness, PLLC nurse practitioner(s) and staff, as is necessary in the medical staff(s) judgment.
I understand that during the course of treatment, health care worker(s) may be exposed to the patient(s) blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker.
I understand that this consent will be valid and remain in effect until it is revoked in writing.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize A New Direction Health & Wellness, PLLC to release any information acquired in the course of my examination(s) and treatment(s) to any authorized agent for the purposes of healthcare, treatment, and payment.
I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY PRACTICES & PATIENT BILL OF RIGHTS:
I have received the A New Direction Health & Wellness, PLLC Notice of Privacy Practices and Patient Rights. I understand I may request and be provided this information at any time.

CONSENT TO RECEIVE AUTOMATED TEXT, EMAIL, AND VOICE MESSAGES
I hereby provide prior express consent to receive automated text, email, and voice messages from A New Direction Health & Wellness, PLLC at the phone number(s) indicated in my A New Direction Health & Wellness PLLC patient profile.
I understand I may revoke my consent at any time by providing A New Direction Health & Wellness written notice of my revocation.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION:
I hereby authorize A New Direction Health & Wellness, PLLC to access historical prescription drug information.
I understand I may revoke my consent at any time by providing A New Direction Health & Wellness written notice of my revocation.

ACKNOWLEDGEMENT OF PERSONAL PROPERTY:
I understand that A New Direction Health & Wellness, PLLC shall not be liable for loss or damages of any personal property.

HEALTH INFORMATION EXCHANGES:
A New Direction Health & Wellness, PLLC endorses, supports, and participates in electronic health information exchange as a means to improve the quality of your health and healthcare experience. Electronic health information exchange provides us with a way to securely and efficiently share patients' clinical information electronically with other health care providers. Using electronic health information exchange helps your health care providers to more effectively share information and provide you with better care. Making your health information available to your health care providers through electronic health information exchange may also help reduce your costs by eliminating unnecessary duplication of tests and procedures.

A New Direction Health & Wellness, PLLC endorses, supports and participates in the Arizona State Immunization and Information System (ASIIS). ASIIS is a confidential, computerized, system that collects and consolidates vaccination data for Arizonians ages 18 years and under and provides tools for designing and sustaining effective immunization strategies to prevent disease and reduce healthcare costs. Information in the ASIIS system can be released only to individuals; individual's parent/legal guardian; individual's healthcare provider; a school or child care center where the individual is enrolled; health insurers if financially responsible for immunizations; healthcare organizations; Department of Health Care Policy and Financing for individuals enrolled in Medicaid.

FINANCIAL POLICIES:

151 W Superstition Blvd.
#5371
Apache Junction AZ 85178

Phone: 480-330-3545
Email: contact@anewdirectionaz.org
Web: www.anewdirectionaz.org

I understand that A New Direction Health & Wellness, PLLC is not contracted with any insurance carrier. I understand that insurance is a contract between myself and my insurance carrier. A New Direction Health & Wellness, PLLC is not a party of this contract.
I understand that A New Direction Health & Wellness, PLLC requires that I disclose all insurance information including primary and secondary insurance cards, as well as, any change of insurance information prior to service(s) rendered. I understand my insurance information will be electronically transmitted to other healthcare providers or healthcare facilities involved in my care. I understand that failure to provide complete insurance information may result in patient responsibility for the service(s) rendered. I understand that it is the insurance company that makes the final determination of my eligibility and benefits. I understand that it is my responsibility to determine my insurance coverage(s) for service(s) rendered. I understand that if my insurance carrier does not provide coverage for services rendered, I am responsible to pay any portion of the charges not covered by insurance. I understand that if my insurance carrier pays me directly, I am responsible for payment and agree to forward the payment to the provider of the service rendered. All copayments, coinsurances, and deductibles may apply. I understand that copayments are the patient's responsibility at the time services are rendered. I understand that if I am uninsured, my account is my responsibility.
No patient will be denied emergency treatment due to his/her inability to pay.
I understand the parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age or older and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. I understand that laboratory tests and diagnostic images such as X-ray, CT, US, and MRI and prescription medication costs are billed separately by the provider of the service rendered and therefore are not included in our charges.

Acknowledgement of Non-Insurance Coverage for Services Rendered
I agree, and it has been explained to me, that services performed by A New Direction Health & Wellness, PLLC are not generally considered and accepted with respect to insurance coverage.

I understand that this requires my payment in full for all services and supplies utilized to render services provided by A New Direction Health & Wellness, PLLC.

I additionally understand that I may not attempt to bill my insurance company for any services or supplies utilized to render services provided by A New Direction Health & Wellness, PLLC.

ACKNOWLEDGEMENTS:
I have received the following information:
1**. Notice of Privacy Practices: Your Information, Your Rights, Our Responsibilities.**
2. **Patients' Bill of Rights.**

CONSENT TO TREATMENT
My signature below indicates that I understand and accept the content of this form and that I acknowledge receiving A New Direction Health & Wellness Notice of Privacy Practices and Patient Bill of Rights.
Client or Client Representative Printed Name: _____
Client or Client Representative Signature: _____
Relationship to Client: _____
Date: _____
Time: _____ AM/PM

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