Geriatrics & Longevity Treatment Specialists, PC

810 Main Street
Hackensack, NJ 07601
201- 488-6728

General Consent for Care and Treatment Consent

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care a this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative — Date

_____ _____

Printed Name of Patient or Personal Representative — Relationship to Patient

_____ _____

Printed Name of Witness Employee — Job Title

_____ _____

Signature of Witness — Date

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ASSIGNMENT OF BENEFITS

Patient name: _____

- I irrevocably assign to **Geriatrics & Longevity Treatment Specialists** all of my rights and benefits under any insurance contracts for payment for services rendered to me by **Geriatrics & Longevity Treatment Specialists.**
- I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by **Geriatrics & Longevity Treatment Specialists** to be released to **Geriatrics & Longevity Treatment Specialists.**
- I irrevocably authorize **Geriatrics & Longevity Treatment Specialists** to file act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.
- I Irrevocably authorize **Geriatrics & Longevity Treatment Specialists** to obtain council and enter legal or other actions on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due it should sums not be paid within the legally prescribed time frame. In the event that **Geriatrics & Longevity Treatment Specialists,** elects to bring a lawsuit or petition for arbitration/dispute resolutions against the insurance carrier.
- I irrevocably assign my rights title and interest under the medical expenses benefits and/or PIP section of any insurances policy under witch I am entitled to proceed for benefits. This assignment shall suit or submit to arbitrations/dispute resolution their claim for any unpaid bills for services rendered from injuries that I sustained in this or any accident.
- In event that his assignment is held invalid for any reason, I hereby authorize **Geriatrics & Longevity Treatment Specialists** to appoint and attorney of its choice. To represent me directly against any insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect bills of **Geriatrics & Longevity Treatment Specialists.**
- **The Undersigned Patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned to Geriatrics & Longevity Treatment Specialists upon receipt of the same.**

A Photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____

PATIENT SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices (effective date_____).

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

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For office use only:

To be completed only if the Acknowledgment is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?

   [ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try and obtain the patient's signature:

_____

_____

_____

_____ _____
Name/Title Date

Geriatrics and Longevity Treatment Specialists
Stefanos Pantagis, MD

810 Main Street
Hackensack, NJ 07601

T: 201-488-6728
F: 201-633-7361

Patient Name:_____ DOB: _____

As a patient with two or more chronic conditions, we would like you to be aware of a new benefit that Geriatrics and Longevity Treatment Specialists, is now offering all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Your assigned clinician in charge of your care is Stefanos Pantagis, MD. Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is <$50.00 of which your portion will be 20% of this, or <$10. If you have a supplemental insurance it will be handled as any other 20% coinsurance.
- Although you may or may not come into the office every month or have a home visit every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one provider can bill for this service for you. Therefore, if another one of your providers has offered to provide you with this service, you will have to choose which person who is best able to treat you and all of your conditions. Please let your provider or our staff know if you have entered into a similar agreement with another practice.
- You have a right to:
    - A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
    - Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program.

Yes___ No___

_____ _____

Patient Signature Date