HudsonPhysicians

AUTHORIZATION FOR TREATMENT: I authorize Hudson Physicians to provide all medical care deemed by my provider to be necessary for examination, diagnosis and treatment of my health concerns.

PAYMENT AUTHORIZATION: I assign my right to payment and request that payment be made on my behalf from my health plan (including Medicare and Medicaid if applicable) or other insurance (including liability, uninsured motorist or medical payments insurance) to Hudson Physicians for services furnished to me by Hudson Physicians. I authorize Hudson Physicians to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor, all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that is not covered by insurance.

RECORD RELEASE: I hereby authorize the release of my health information (which I understand may include information, if any, about substance abuse, mental health and HIV/AIDS) by Hudson Physicians to my referring provider and any health care provider currently involved in my treatment and from my referring provider and any health care provider currently involved in my treatment to Hudson Physicians.

MEDICAL HOME AUTHORIZATION: Hudson Physicians is a medical home facility. A medical home facilitates partnership between patients, their providers, and the rest of their designated health care team. It provides comprehensive primary care for all patients and allows better access to health care, increased satisfaction, and improved overall health. Patients may change their medical home status at any time.

I choose Hudson Physicians as my primary medical home clinic: ☐ Yes ☐No

CONSENT FOR TREATMENT OF MINORS: Hudson Physicians requires that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments (except for limited circumstances where a minor is legally able to provide consent under applicable law). In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this Consent for Treatment of Minors to be kept on file at Hudson Physicians. I authorize care and treatment for my unaccompanied minor child referenced as *Patient's Printed Name* below. I agree to be financially responsible for the services rendered to my minor child by Hudson Physicians in my absence. The following individuals may authorize treatment for my minor child:

Name:	Relationship to Minor Child:
_____	_____
_____	_____
_____	_____

AUTHORIZATION FOR APPOINTMENT REMINDERS: By selecting an appointment reminder type below, you are authorizing Hudson Physicians to send appointment reminders:

Appointment Reminder Methods (choose only 1):

☐Phone Call Phone Number: _____

☐Text Message Phone Number: _____

☐E-mail E-mail Address: _____

Patient's Printed Name:_____ **Date:**_____

Signature of Patient/Patient Representative:_____

If signed by Patient Representative, specify relationship to patient:_____