BlueSky HOUSE CALLS
1601 17th Ave S, Nashville, TN 37212
Phone: 615-340-6840 Fax: 615-600-4804

Consent to Receive Medical Care

I am aware that BLUESKY HOUSECALLS ("BSHC") provides medical services based on information provided to BSHC by the patient, their family or any trained medical staff working or residing in the patient's place of residence. I understand that accurate and complete medical information is essential to the medical services provided by BSHC. I understand BSHC will not accept liability for inaccurate and incomplete information. I give my consent to receive medical care by professionals associated with BSHC as a result of such information.

Guarantee of Payment and Assignment of Insurance Benefits

I understand that I am financially responsible for the services provided to me by BSHC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to BSHC for any services provided to me by BSHC. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to BSHC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by BSHC, now or in the future. I agree to immediately remit to BSHC any payments that I receive from any source for the services provided to me and I assign all rights to such payments to BSHC. The undersigned hereby guarantees payment to BSHC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection. The undersigned here agrees to pay interest at a rate of 18% annual percentage rate on all outstanding balances. Interest accrues starting 30 days after all expected insurance payments have been received and balance owed statements have been sent.

Acknowledgement of Receipt of Notice of Privacy Practices and Assignment of Insurance Benefits

I, _____, give my consent to receive medical care by professionals associated with BLUESKY HOUSECALLS and also acknowledge BLUESKY HOUSECALLS has provided me access to a copy of the Notices of Privacy Practices. For additional information I am aware that I may contact BLUESKY HOUSECALLS.

_____ _____
Patient Signature Date

_____ _____
Patient Representative's Signature* Relationship to Patient

(Must provide documentation of healthcare proxy, consent considered invalid without documentation)

OFFICIAL USE

Patient Name: Reviewed and approved by: