HudsonPhysicians

PATIENT AUTHORIZATION

AUTHORIZATION FOR TREATMENT: I authorize Hudson Physicians to provide all medical care deemed by my provider(s) to be necessary, appropriate or helpful for examination, diagnosis and treatment of my health concerns. I understand such services may include examination, medical and surgical treatment, imaging, laboratory, immunizations and other medical services performed or prescribed. I agree that the practice of medicine is not an exact science and that no guarantee or promises have been made as to the results to be obtained.

PAYMENT AUTHORIZATION: I assign my right to payment and request payment be made from my health plan (including Medicare and Medicaid, HMO, group health plan, health, liability, uninsured motorist or other insurance) ("Health Plan") 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 my Health Plan, all medical or other information that is needed to determine the benefits payable for services. I agree to pay all co-payments, deductibles and other charges not covered by my Health Plan within 30 days of receipt of the billing statement. If I can't pay my statement in full, I will contact Hudson Physician's billing office to arrange a payment plan which may be offered in Hudson Physician's sole discretion.

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:**
_____	_____
_____	_____
_____	_____

APPOINTMENT REMINDERS & COMMUNICATIONS: I authorize Hudson Physicians to send appointment reminders or other communications as stated below. I understand that Hudson Physician may use other methods of communication such as mailings and online portals.

Methods (choose only 1):

☐ Phone Call (leaving message) Phone Number: _____
☐ Text Message Phone Number: _____
☐ E-mail E-mail Address: _____

TERM: This Authorization is effective as of the date signed and is valid for a period of ten (10) years unless revoked in a writing by the Patient or Patient Representative delivered to Hudson Physicians or superseded by a new authorization.

Patient's Printed Name: _____ **Date:** _____
Signature of Patient/Patient Representative: _____

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