Medical Consent Form

AUTHORIZATION TO GIVE CONSENT TO MEDICAL CONSULTATION AND TREATMENT: I hereby voluntarily consent to medical consultation and treatment from Starting Line Wellness, LLC; encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) assessment of routine laboratory work and prescription of medications as promulgated by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the Starting Line Wellness LLC's medical Providers and staff, as is necessary in the medical staff's judgment. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

AUTHORIZATION TO **RELEASE INFORMATION:** I hereby authorize Starting Line Wellness to release any information acquired in the course of my examination and treatment 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:** I understand that information about me will be kept confidential. I understand that records and information about me shall not be released without my consent or the consent of my authorized representative, except where the release is in accordance with applicable law. I give clinicians employed or contracted with Starting Line Wellness, LLC permission to share records with and discuss my medical condition with my other caregivers, including, without limitation, the staff of an residence/facility where I reside, or any hospital where I am hospitalized, my attending physician, and other persons employed by Starting Line Wellness involved in my care.

AUTHORIZATION TO **ACCESS RX HISTORY INFORMATION:** I hereby authorize Starting Line Wellness to access historical prescription drug information.

FINANCIAL POLICIES: I authorize Starting Line Wellness to file a claim with my insurance carrier for services rendered. I authorize payment of medical benefits by any insurance carrier to either the Starting Line Wellness or myself. I understand that insurance is a contract between myself and my insurance carrier. The Starting Line Wellness is not a party of this contract. In order to properly bill your insurance carrier we require that you disclose all insurance information including primary and secondary insurance cards, as well as, any change of insurance information within 60 days of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately. All copayments, coinsurances, and deductibles may apply. I understand that hospital/lab services (i.e. laboratory tests and diagnostic images such as X-ray, CT, US, and MRI) are billed separately by the hospital and therefore not included in our charges.
The patient will need to contact the hospital/lab regarding charges and payments.

I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me.

My signature below indicates that I understand and accept the content of this form.

Signature____Date_____________Time_
____**AM/PM** Patient or Patient Representative

Print Patient Name____Date of Birth______________________________

If not the patient: Relationship to Patient ____

50 West Main Street Hopkinton, MA 01748 / PH: (508) 435-5319 / Fax: (508) 435-2213

Starting Line Wellness

50 West Main Street
Hopkinton, MA 01748
Tel: (508) 435-1250
Fax: (508) 435-2213

Physician / Provider Consent Form

I, ____, give permission to
____ (Physician Name/Provider) to release
the medical information for ___________________________________(Resident Name/myself)
to Starting Line Wellness, LLC to provide medical consultation as the primary care physician on site at The Communities at Golden Pond.

Signed ____

Date _________________________

Please fax document to (508) 435-2213.

Thank you,

Starting Line Wellness, LLC

Starting Line Wellness, LLC

Today's Date: ____________

Patient Information

Name Last	First	MI	
Other Name	Social Security #	Date of Birth	
Street Address	City	State	Zip Code
Home Phone #	Primary Care Physician	Sex ☐ Male ☐ Female	
Employer Name	Employer Phone #	Marital Status ☐ Single ☐ Married ☐ Other	
Cell Phone	E-Mail		

Responsible Party Information Complete *only* if not Patient

Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent		
Street Address	City	State	Zip Code
Home Phone #	Employer Name		
Work Phone #	Employer Address		

Primary Insurance Information

Insurance Company Name		Insurance Co. Phone #	
Street Address	City	State	Zip Code
Policy #	Group #	Plan #	Date Policy Became Effective
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent		Subscriber Social Security #	
Subscriber Name		Subscriber Date of Birth	
Subscriber Address		Subscriber Employer	

Secondary Insurance Information

Insurance Company Name		Insurance Co. Phone #	
Street Address	City	State	Zip Code
Policy #	Group #	Plan #	Date Policy Became Effective
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent		Subscriber Social Security #	
Subscriber Name		Subscriber Date of Birth	
Subscriber Address		Subscriber Employer	

Emergency Contact Information

Emergency Contact Name	Relationship	Home Phone #	Work Phone #

Assignment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

Signature of patient or legal guardian ____________ Date ____________

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

Signature of patient or legal guardian ____________ Date ____________

Lifetime Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of patient or legal guardian ____________ Date ____________