BRT CLINICAL NURSING SERVICES, INC.
Phone: (951) 386-9489 | Email: info@brtclinical.com

PATIENT CONSENT & AUTHORIZATION

Mobile & Home-Based Care | Telehealth | Advanced Wound Care | Chronic Condition Management

Patient Information

Patient Name:	**Date of Birth:**
Address / Facility:	Phone Number:
Legal Representative / POA:	Relationship:
Date of Visit:	BRT Clinical Provider / NP:

Purpose of This Packet

This packet documents consent, authorization, patient rights, privacy practices, and financial/insurance acknowledgments for services furnished by BRT Clinical Nursing Services, Inc. ("BRT Clinical"). Please complete and sign all applicable sections before or at the start of care.

Services Covered

BRT Clinical may provide in-home, mobile, facility-based, and/or telehealth services within the scope of its licensed clinicians. Services may include primary care evaluation and follow-up, post-hospital/transitional care, advanced wound care, medical weight management, including GLP-1 medications, chronic disease management, same-day virtual care, in-home health evaluations, care coordination, and other clinically appropriate services.

We provide home-based and/or telehealth medical services for elderly, bed-bound, homebound, and medically complex patients who may have difficulty visiting a physician office or wound care clinic.

Important

Signing this packet does not guarantee that any particular service, medication, test, procedure, or item will be medically appropriate or covered by an insurer. Treatment decisions are based on clinical assessment, applicable law, payer requirements, and the patient's preferences.

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CONSENT FOR SERVICES, AUTHORIZATION FOR TREATMENT, AND PATIENT ACKNOWLEDGMENTS

AUTHORIZATION TO ENTER HOME OR CARE SETTING

I authorize BRT Clinical, its licensed clinicians, employees, contractors, and authorized representatives to enter my home, facility, or other agreed care setting to provide medically necessary services. I understand that I may revoke this authorization in writing, subject to actions already taken in reliance on it.

- Access relevant medical records and health information as permitted for treatment, payment, and healthcare operations.
- Communicate with my primary care clinician, specialists, home health or hospice agencies, facility staff, pharmacies, laboratories, imaging providers, insurers, and other persons or organizations involved in my care.
- Coordinate clinically appropriate home-based, mobile, telehealth, wound care, chronic condition management, transitional care, and related services.

CONSENT FOR SERVICES

I consent to evaluation and medically necessary care by BRT Clinical. Depending on my needs and the clinician's scope of practice, services may include:

- History and physical assessment, diagnosis, treatment planning, medication reconciliation, and follow-up.
- Primary care, post-hospital/transitional care, pulmonary care, chronic disease management, and care coordination.
- Wound assessment, measurements, photographs when authorized, dressing changes, topical treatment, compression therapy when appropriate, negative-pressure wound therapy management, debridement when clinically indicated and within scope, and coordination of advanced wound therapies.
- Ordering or coordinating laboratory testing, diagnostic imaging, referrals, durable medical equipment, pharmacy services, and other medically necessary care.
- Telehealth or virtual visits when clinically appropriate and agreed upon.
- In-home health evaluations and other services within the clinician's legal scope and BRT Clinical policies.

☐ I CONSENT to the services described above and other medically necessary services within the treating clinician's scope.

☐ I decline the following service(s), if any: _____

AUTHORIZATION / CONSENT FOR TREATMENT

I authorize BRT Clinical clinicians to examine, evaluate, diagnose, and treat me as clinically appropriate. I understand that healthcare involves uncertainties and that no guarantee has been made regarding the outcome of any treatment or procedure. I may ask questions, request alternatives, or withdraw consent for a proposed treatment before it is performed, except as otherwise permitted by law.

Wound Care Procedures

When clinically indicated, wound care may include cleansing, debridement, cultures, topical therapies, compression, negative-pressure wound therapy, and coordination or application of advanced wound products when permitted. Risks vary by procedure and may include discomfort, bleeding, infection, skin injury, delayed healing, allergic reaction, or worsening of the wound. The clinician will discuss material risks, benefits, and reasonable alternatives for procedures requiring specific informed consent.

CONSENT TO CLINICAL PHOTOGRAPHY

Clinical photographs or digital images may be used to document wounds or other findings for treatment, care coordination, quality review, billing, prior authorization, or insurance documentation. Images are part of the medical record and are protected under applicable privacy laws.

☐ I CONSENT to clinical photography for treatment, payment, and healthcare operations.

☐ I DO NOT CONSENT to clinical photography. I understand this may affect documentation, authorization, or coordination of certain services.

Images will not be used for marketing, public education, social media, or other promotional purposes without a separate written authorization.

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TELEHEALTH CONSENT

I understand that telehealth uses electronic communications to allow a clinician and patient in different locations to communicate. Telehealth may include audio/video technology, electronic transmission of health information, remote review of records, and other permitted technologies.

- Potential benefits include improved access, convenience, and continuity of care.
- Limitations may include technology failure, reduced ability to perform a hands-on examination, privacy/security risks, and the need for an in-person evaluation when clinically necessary.
- I may stop or refuse a telehealth visit at any time. If an emergency is identified, I may be instructed to call 911 or seek emergency care.
- I am responsible for participating from a reasonably private location and providing accurate information about my location when requested.

☐ I consent to telehealth services when clinically appropriate.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

I certify that the information I provide regarding insurance and eligibility is accurate. To the extent permitted by my plan and applicable law, I authorize payment of benefits directly to BRT Clinical for covered services furnished by its clinicians and authorized staff. I authorize BRT Clinical to submit claims and supporting documentation necessary for payment.

Coverage: ☐ Medicare ☐ Medi-Cal ☐ Medicare Advantage / HMO ☐ Commercial Insurance ☐ Direct Pay / Guarantor

Insurance / Plan: _____

Member / Beneficiary ID: _____

I understand that insurance authorization or verification is not a guarantee of payment. I may be responsible for lawful deductibles, copayments, coinsurance, non-covered services, or denied charges, except where collection is prohibited by law or contract. BRT Clinical will follow applicable Medicare, Medi-Cal, and payer rules regarding patient financial responsibility.

MEDICARE AUTHORIZATION

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made to BRT Clinical or the appropriate enrolled billing entity for covered services furnished to me. I authorize disclosure of information to the Centers for Medicare & Medicaid Services (CMS), its contractors, Medicare Advantage plans, or other applicable payers as necessary to determine benefits and process claims.

RELEASE / EXCHANGE OF HEALTH INFORMATION

I authorize BRT Clinical to obtain, use, and disclose health information as permitted by law for treatment, payment, and healthcare operations. This may include communication with physicians and other clinicians, hospitals, home health and hospice agencies, skilled nursing or assisted living facilities, pharmacies, laboratories, imaging providers, insurers, payer representatives, and other organizations involved in my care.

This general consent does not replace a separate authorization when one is required by law for specially protected information or for uses outside treatment, payment, and healthcare operations.

COMMUNICATIONS / NOTICES

BRT Clinical may contact me regarding appointments, scheduling, care coordination, test results, referrals, billing, insurance follow-up, or other healthcare matters using the contact information I provide. I understand that ordinary email or text messaging may carry privacy risks. I may request reasonable alternative communications.

☐ I agree to receive healthcare-related calls/voicemails.

☐ I agree to receive healthcare-related text messages.

☐ I agree to receive healthcare-related email messages.

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AUTHORIZED FAMILY MEMBERS OR OTHERS INVOLVED IN CARE

I authorize BRT Clinical to discuss my care and/or billing with the person(s) listed below to the extent I indicate. I may change or revoke this authorization in writing.

Name	Relationship	Phone	All	Medical	Billing / Emergency
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Unless I revoke it earlier, this authorization remains effective for 12 months from the date signed or until I am discharged from BRT Clinical, whichever occurs first, unless a different period is required by law.

ADVANCE DIRECTIVE ACKNOWLEDGMENT

I understand that I have the right to participate in decisions about my healthcare, accept or refuse treatment, and create an Advance Health Care Directive. BRT Clinical does not require an Advance Directive as a condition of receiving services.

☐ I have an Advance Directive and will provide a copy.

☐ I have an Advance Directive, but a copy is not currently available.

☐ I do not have an Advance Directive.

☐ I would like information about Advance Directives.

PATIENT RIGHTS

- Receive considerate, respectful, and nondiscriminatory care consistent with applicable law.
- Receive information about proposed care, material risks and benefits, reasonable alternatives, and expected financial responsibility when known.
- Participate in development of the plan of care and ask questions about diagnosis, medications, procedures, wound care, referrals, and follow-up.
- Accept or refuse treatment and be informed of reasonably foreseeable consequences of refusal.
- Have medical records and protected health information handled confidentially and request access to records as permitted by law.
- Voice concerns or complaints without retaliation or interruption of medically necessary care.
- Request reasonable communication accommodations and identify persons involved in care.

PATIENT RESPONSIBILITIES

- Provide complete and accurate information about health history, symptoms, medications, allergies, insurance, contact information, and other information relevant to care.
- Inform BRT Clinical of significant changes in condition, medications, insurance, contact information, facility location, or legal representative.
- Participate in the agreed plan of care and ask questions when instructions are not understood.
- Provide a safe and appropriate environment for home or mobile visits and treat clinicians and staff respectfully.
- Notify BRT Clinical as soon as possible if unable to keep a scheduled visit.
- Provide copies of Advance Directive, Power of Attorney, conservatorship, guardianship, or other representative documents when applicable.

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NOTICE OF PRIVACY PRACTICES - SUMMARY

BRT Clinical protects individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and California privacy laws. This section is a summary of common privacy practices and patient rights. BRT Clinical may provide a separate, more detailed Notice of Privacy Practices when required.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

- Treatment: BRT Clinical may use or disclose health information to clinicians and organizations involved in providing or coordinating care, including referrals, prescriptions, consultations, laboratories, imaging, medical supplies, and other healthcare services.
- Payment: BRT Clinical may use or disclose information to verify coverage, obtain authorization, submit claims, respond to payer requests, coordinate benefits, and collect lawful amounts due.
- Healthcare operations: BRT Clinical may use or disclose information for quality improvement, compliance, audits, credentialing, training, patient safety, business administration, and other permitted operations.

YOUR HEALTH INFORMATION RIGHTS

- Request access to or copies of health information, subject to applicable legal limitations and permitted fees.
- Request correction or amendment of information you believe is inaccurate or incomplete.
- Request an accounting of certain disclosures when the law provides that right.
- Request restrictions on certain uses or disclosures; BRT Clinical may not be required to agree to every request.
- Request confidential or alternative communications at a reasonable location or by a reasonable method.
- Request a paper or electronic copy of the applicable Notice of Privacy Practices.
- File a privacy complaint without retaliation.

SPECIAL AUTHORIZATIONS

Some categories of information may receive additional protection under federal or California law. When a specific written authorization is legally required, BRT Clinical will obtain that authorization before using or disclosing the information unless an exception applies.

NONDISCRIMINATION

BRT Clinical provides services without unlawful discrimination. Care and access to services will be provided consistent with applicable federal and California civil-rights and nondiscrimination requirements.

QUESTIONS, PRIVACY REQUESTS, OR COMPLAINTS

Contact BRT Clinical Nursing Services, Inc. at (951) 386-9489 or info@brtclinical.com for questions about care, privacy requests, records, billing concerns, or complaints. Patients may also submit privacy complaints to the U.S. Department of Health and Human Services Office for Civil Rights. Filing a complaint will not affect the patient’s right to receive care.

Emergency Notice

BRT Clinical is not a substitute for emergency medical services. For a medical emergency, call 911 or go to the nearest emergency department.

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PATIENT ACKNOWLEDGMENT & SIGNATURES

By signing below, I acknowledge that I have had an opportunity to read this Patient Consent & Authorization packet, ask questions, and receive answers. I consent to the services and authorizations selected above. I understand that I may revoke certain authorizations in writing, subject to applicable law and actions already taken in reliance on them.

Patient Name: _____

Patient Signature: _____

Date: _____

Legal Representative Name (if applicable): _____

Relationship / Authority: _____

Legal Representative Signature: _____

Date: _____

VERBAL CONSENT / FACILITY DOCUMENTATION (IF APPLICABLE)

If written signature cannot reasonably be obtained at the time of service, licensed staff may document verbal consent consistent with BRT Clinical policy and applicable law.

Name of Staff Obtaining Verbal Consent: _____

Date / Time: _____

Facility / Organization (if applicable): _____

BRT CLINICAL PROVIDER / STAFF

Provider / Licensed Clinician Signature: _____

Date: _____

BRT Clinical Representative / Staff Signature: _____

Date: _____

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