

**ALF Consent to Treat with NPP Attestation**

KG Health Partners has been chosen to provide comprehensive Podiatry, Wound Care and/or Dermatology services to the residents of: \_\_\_\_\_ . On a periodic basis, KG Health Partners will provide medical management and treatment of any conditions related to the specialties listed above. KG Health Partners accepts Medicare assignment; however, Medicare will only pay for service it deems 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. If Medicare and/or your insurance company determines that a particular service, although it would otherwise be covered, is not 'reasonable and necessary' under Medicare program standards, they will deny payment for that service. Any questions concerning services rendered by KG Health Partners including treatment and billing, can be directed to our office at (727)796-6900.

Please sign below to acknowledge receipt of KG Health Partners Notice of Privacy Practices effective January 1, 2018.

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (or legal representative): \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_ Legal Representative: \_\_\_\_\_ Other (explain below): \_\_\_\_\_

**For Field/Facility Staff Use Only NPP:**

If the individual or legal guardian did not sign above, field staff must document when and how the Notice was given to the individual, why acknowledgment could not be obtained, and the efforts that were made to obtain it. Complete the checkboxes and forward to Compliance Officer for review and completion.

Notice of Privacy Practices effective January 1, 2018, provided to individual on \_\_\_\_\_ (date)

In Person  Mailing  Email  Other \_\_\_\_\_ Reason individual

or legal guardian did not sign this form:

- Did not want to
- Did not respond after more than one attempt
- Other \_\_\_\_\_

Field Staff Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Field/Facility- Staff Use Only Consent:**

The following good faith efforts were made to obtain the individual or legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

- In person conversation \_\_\_\_\_
- Telephone contact \_\_\_\_\_
- Mailing \_\_\_\_\_
- Email \_\_\_\_\_
- Other \_\_\_\_\_

Office/Facility Staff Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_