NP Pulse
Professional Care. Personal Touch. Right at Home.

1. Consent for Treatment – NP Pulse Mobile Practice

Patient Name: _____ **DOB:** _____ **Date:** _____

I hereby consent to receive medical evaluation and treatment from **NP Pulse Mobile Practice**, including but not limited to assessment, diagnosis, treatment, and follow-up care performed by a licensed Nurse Practitioner or designated clinical staff.
I understand that:

- Mobile visits occur outside a traditional clinic setting.
- I have the right to refuse or withdraw consent at any time.
- All information is confidential and protected under HIPAA.
- Treatment may include prescribing medications, ordering labs/imaging, and coordinating care.

Patient/Legal Representative Signature: _____ **Relationship:** _____

Provider Signature: _____ **Date:** _____

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2. Consent for Mobile Services & Home Entry

I authorize **NP Pulse Mobile Practice** to enter my home or place of residence for the purpose of providing medical care.
I acknowledge that:

- I must provide a safe environment for the provider.
- Pets must be secured during the visit.
- A responsible adult must be present if the patient lacks decision-making capacity.
- The provider may reschedule the visit if the environment is unsafe.

Patient/Legal Representative Signature: _____ **Date:** _____

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3. Consent for Telehealth Services (if applicable)

I consent to receive medical care via telehealth when appropriate. I understand that:

- Telehealth may involve audio, video, or digital communication.
- Limitations include potential technology failures or reduced assessment accuracy.
- I may request an in-person visit at any time.

Patient/Legal Representative Signature: _____ **Date:** _____

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4. Consent for Release of Medical Information (HIPAA Authorization)

I authorize **NP Pulse Mobile Practice** to release or obtain medical records related to my care to/from the following individuals or facilities:

Name/Facility: _____ **Purpose of Release:** _____

This authorization is valid for one year unless revoked in writing. I understand my records may include sensitive information (e.g., mental health, HIV, substance use) unless I specify restrictions.

Patient/Legal Representative Signature: _____ **Date:** _____

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5. Financial Responsibility & Billing Consent

I agree to be financially responsible for all services provided by **NP Pulse Mobile Practice**, including:

- Self-pay fees
- Any charges not covered by insurance
- Fees related to mobile visits or after-hours services

I understand:

- Payment is due at the time of service unless other arrangements are made.
- I will receive an invoice/receipt for all services performed.
- Failure to pay may result in service termination.

Patient/Legal Representative Signature: _____ **Date:** _____

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6. Acknowledgment of Practice Policies

By signing below, I acknowledge that I have received and understand the following:

- Notice of Privacy Practices (HIPAA)
- Mobile visit policies
- Cancellation/no-show policy
- Medication management policy

Patient/Legal Representative Signature: _____ **Date:** _____