PARKVIEW INTERNAL MEDICINE

One Time Authorization Form

PATIENT NAME _____DATE_____

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named facility, all charges for such services and incidentals incurred. Should the account be referred to an agency for collection, I shall pay reasonable fees and collection expenses.
Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services.

Responsibility for copay amounts: I agree to be fully responsible for paying co-pay and/or co-insurance of set amounts at the time of physician's visit. Further, I understand that if my copay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. Any bill that is received, once insurance has paid, will be due upon receipt.

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, Medicaid, major medical benefits, insurance disability benefits, or injury benefits payable to or for the above said patient until the account is paid in full.

INITIAL: _____

Privacy Agreement: Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today a copy of the provider's notice of privacy policies. I consent to the provider's use of protected health information as described in the notice for treatment and payment of healthcare claims.

INITIAL: _____

Reminder Notification: I agree that the practice may call for appointment reminders, notify me of test results and to remind me of any testing or screening that is due and needs to be scheduled. I agree, if I have an answering machine or voice mail, to allow the doctor or staff members to identify themselves, as well as myself and to notify me of my appointment or tell me that test results are back. I understand that the doctor or staff will not leave test results on my answering machine or voice mail.

INITIAL: _____

ePrescribing Consent: ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.
- **External prescription history** – allows the prescriber to acquire prescription history from external sources such as the SureScripts prescription database.

  By signing this consent form you are agreeing that Parkview Internal Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

  Understanding all of the above, I hereby provide informed consent to Parkview Internal Medicine to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

By signing this agreement, I agree to all statements outlined above. I understand that I have the right to have any questions relating to this agreement answered to my satisfaction by Parkview Internal Medicine.

INITIAL: _____

SIGNATURE _____ DATE_____