Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

- The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
- It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
- Over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

☐ I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

☐ I do not give permission to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Name: _____

Patient signature _____

Signature of Patient or Legal Guardian _____

Consent to Treatment

I hereby give my permission for Lenita Hanson MD PA dba Hanson Diabetes Center (The Practice) to give me medical treatment either in office or as a telehealth/digital visit. I hereby authorize the assignment of benefits payments directly to Lenita Hanson MD PA for all my insurance claims related to services received.

I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs such as Co-pays, deductibles and non-covered services at the time of service.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my Provider.
- I permit a copy of this authorization to be used in place of the original.

Patient Name: _____

Patient signature _____

Signature of Patient or Legal Guardian _____

Patient Name: _____

Patient signature _____

Signature of Patient or Legal Guardian _____

Our Policy Regarding Patient Financial Responsibility

Managed Care Plans - Lenita Hanson MD PA files insurance claims for managed care groups with which we participate. We accept payments for covered services from insurance plans in accordance with our contract. Patients are responsible for applicable co-insurance and deductible amounts and for any and all payments for services that are not covered by insurance. All patient payments are due at the time of the visit.

Medicare - Lenita Hanson MD PA files insurance claims for Medicare on assignment. We accept Medicare allowable amounts and the patient is responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance - If the patient's insurance is with a company with which we do not participate, the patient is responsible for payments of their bill at the time of service. We do not file non-assigned claims to non-participating insurance companies.

Self-Pay - All services are required to be paid in full at time of service.

Telehealth/Virtual Visits - If deemed feasible, in order to maintain continuity of my healthcare I permit the office to conduct my visit as a telehealth or virtual visit. I am responsible of any out of pocket expenses.

Cancellations - Hanson Diabetes Center asks that you notify us 48 hours in advance if you are unable to keep your appointment. Patient who consistently fail to show for their appointment and /or fail to notify us may be asked to find another physician. Hanson Diabetes Center reserves the right to charge a "No show" fee of $50 per occurrence.

Medical Care - Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the policies and guidelines of our patient's insurance plan. **It is however, the responsibility of the patient to know and understand those policies and guidelines. It is also the responsibility of the patient to seek medical care only with physicians participating within their plan**.

Devices and Diagnostics - If recommended by the doctor, there will be an additional charge separate from your office visit for services such as but not inclusive of diabetes technology and devices insertion, training and interpretation; ankle brachial index testing; Electrocardiograms and office hemoglobin A1C

Medical Records and Forms - There is a charge per federal guidelines for medical record requests and completion of forms that is due at time of request. There is no charge for records sent to other healthcare providers or forms for work or school, jury duty, satisfactory health letter, prior authorizations, or DME forms. **Please note the completion of Prescription Assistance Forms is an optional service provided based on staff availability and you may be charged a flat fee**.

I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (Refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with Lenita Hanson MD PA incurred by myself, or my dependents. I have read and understand the office policy stated above and agree to accept the responsibility described.

_____ _____

Patient / Responsible Party Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office or provided at your request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files are stored in our secured electronic health record system. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, text or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or your Provider.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I have read and understand this document and consent to the use of my PHI as indicated above.

Patient Name: _____

Patient Signature: _____

Date: _____

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals with whom you authorize our office to discuss your care.

I give you permission to share my health information with:

1. Name _____Relationship _____
Phone_____
2. Name _____ Relationship _____
Phone_____

****
****

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign
☐ Due to an emergency, it was not possible to obtain acknowledgment
☐ We were not able to communicate with the patient.
☐ Other (Please provide specific details)

_____ _____
Employee Signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices. This form does not constitute legal advice and covers only federal, not state, law.