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I, _____ (print name) _____Dated, do hereby consent and acknowledgement my agreement to the terms set forth in the HIPAA and any subsequent changes in office policy. I understand that this consent shall remain, in force from this time forward. In addition to the above, a condition of being admitted for treatment as an outpatient of the Preferred Health Solutions (PHS). I acknowledge the following **Consent of Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits, Medicare/Medicaid assignment of Benefit, Frequency Right / Hotline Procedure, and Additional Understandings**. I understand by acknowledging this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and possibly termination of services from my doctor and his practice.

Condition of Admittance

As a condition of being admitted for treatment as an outpatient of the Preferred Health Solutions (PHS). I agree to-the following:

1. **Consent of Treatment:** I voluntarily request and consent to Treatment by PHS, I authorize the treating physician(s) and their assistants and PHS to perform medical treatment and technical procedures, to administer drugs, and to render **care** as their judgment may indicate to be necessary or advisable.

I understand that the services provided to me by PHS are provided by doctors or physician assistants, occupational therapists and nurse practitioners. PHS will maintain a record of the care and services you receive. This consent only covers your protected health information created while you are a patient of PHS. Your protected health information pertains to your diagnosis and or treatment by PHS, Including but not limited to information-concerning medical illness (except for psychotherapy notes), *use* of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results medical history, treatment history, treatment progress or any other such related information. By signing this form, you consent to PHS's use and/or disclosure of pre-existing health information about you for treatment, payment, health care operations and as otherwise allowed by law, Our Notice of Health, Information Practice provides information about how PHS and physician on its medical staff may use and /or disclose protected health Information about you for treatment, payment, health care operations and as otherwise allowed by law. Consent for any major surgical procedures or other procedures by physician/surgeons requiring additional consent will be requested by the physician performing such and shall be obtained preceding with exception for those procedures considered necessary for extreme, life-saving emergencies.

2. **Authorization to Release Medical Information:** I authorize PHS any treating physician to furnish requested information from patient medical and other records to

a. Any insurance company or third party payer for the purpose of payment on the account of PHCS or a treating medical provider.
b. Any other persons or entities financially responsible for the patients treatment and;
c. Representatives of governmental agencies in accordance with law. Such [information may include, but is not limited to Information about communicable diseases such as AIDS.
I authorize release of information from or the review of the patient records for medical audit, utilization reviews, or quality assurance reviews. I authorize PHS to release information from our copies of the patient medical records to the referring physician or to any skilled nursing facility or health care facility which I may be transferred.
d. Lastly, only the designated person listed are authorized to read or have access to or be included in patient care conference or discussers on my behalf. I understand that this documents does not supersedes traditional power of attorney yet it is my intent that only the person(s) listed are hereby granted access to my records.
3. **Assignment of Insurance Benefits:** I Assign to PHS all right to file and interest in any payment due me for services described herein as provided in a insurance policy or employee benefit plan, I further assign all rights to payment due to me for physician services under said policies to physicians which provide treatment for me while I am an PHS patient I understand I am responsible for providing to PHS all insurance Information available at the time of this hospital visit to allow for verification: I agree to pay any amounts due the hospital or physicians that are not covered by insurance. I am responsible to inform the agency if I change to an HMO. Medicare Advantage / HMO: I may be liable for payment of my Medicare / Medicaid Services.
4. **Medicare / Medicaid Assignment of Benefit:** I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or tis intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefit be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.
Medicaid: I understand that Medicaid recipients are responsible for payment for any medical services received that are beyond the scope of the South Carolina Medicaid program, as determined by the South Carolina Department of Health and Human Services. All such payments are due and payable at time of discharge.
5. **Frequency Rights/Hotline Procedure:** I understand that Dr. Rukudzo Mazaiwana will be my visiting or telemedicine doctor or his designated Physician Assistant/Nurse Practitioner. I have been notified of my rights to voice a complaint and may direct that complaint with the Secretary of the Health and Human Service. I may also direct a complaint to the Management of the Practice to do the investigation of the complaint which will be initiated within 10 calendar days and resolved within 30 calendar day's receipt. I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any abuse, neglect and exploitation agency testing policy and hazardous disposal. I have been advised verbally and in writing the purpose and my right pertaining to the collection of

information and the Privacy Act. HIPAA – I have received the Notice of Privacy Practices and consent to the agency's use and / or disclosure of protected health information for the patient.

6. **Additional Understandings:**

a. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me with respect to the results of any examination or treatment to be performed by PHS.

b. I authorize PHS to use its discretion to retain or dispose of any issue removed during any treatment or diagnostic procedure.

c. All accounts over 60 days old will be considered delinquent and payable immediately. if payment is not received by 90 days, the account will be referred to an outside collection agency or attorney's office and will be reported to the credit bureau. The patient or responsible party will be responsible for all attorneys and/or collection agency fees' and court cost.

Medication Use Agreement

I, the above signee, understand that I have hindrances that has not been adequately controlled with other medications and that my function is limited by these hindrances. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the hindrances. I will take the medication only as prescribed; I will not take any sedatives, alcohol or other pain medications without the prior approval of any doctor. I understand that the medication will be prescribed only by **Dr. Mazaiwana / PHS NP/PAs** and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. I will not seek or accept any medications for pain other than those prescribed by my doctor. "Medications for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs. Medication refills will be provided as written prescriptions only. No refills will be given prior to the next schedule appointment date. If I do not keep my appointment, I will not receive a refill. Appointment cancellations with less than one workday's notice or no-show appointments may constitute grounds for immediate termination of this agreement. I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped. I understand the lost or stolen medication will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of police report will be required for any lost or stolen narcotics prescriptions. I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and copy of this agreement when a referral is made. In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my doctor,
2. I give, sell or in any way distribute prescribed medications to any other person(s),

3. I in any way attempt to forge or alter a prescription,
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with the medication presents a danger to my well-being or safety,
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescription only at the pharmacy I listed below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy with a copy of this agreement. I understand that any alternation in my medication prescriptions will require a new written agreement.

Pharmacy Name _____

Pharmacy Address_____

_____

Pharmacy Telephone/Fax_____

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) provide 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.

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 or information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional services 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 service 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 may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal purse of providing care means that such records may be left, at least temporarily, in administrative area such as the front office, examination room, etc. Those records will not be available to persons other than office staff.

You agree to the normal procedures utilized within the **office** for the handling of charts, patient records, PHI another documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text, US mail, 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 and valuable or informative.
3. The practice utilizes & number of vendors and business partners 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 payer in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or the doctor.
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 patient with access to their records in accordance with state and federal laws.
8. We may charge, add, delete or modify any of these provision to better serve the needs of the 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 obligated, internal policies to conform to your request.

I the undersigned do hereby agree to the terms, conditions, and rules set forth in the **Conditions of Admittance, Medication Use Agreement,** and **HIPAA Information** sections. Furthermore, I certify that all the information I provide is accurate and complete. I will inform the clinic should any information change in the future, therefore indemnifying the physicians and staff of my healthcare for information not provided or inaccurate for any and all future outcomes. I understand that I am an individual and treatment for me is on an individual basis. I recognize that I may revoke this consent at any time in writing, except at the extent that period has been taken in reliance on it. I have read this agreement and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

_____

Signature of Patient (or Authorized Party / Relationship) Date Printed Patient Name

_____

Signature of Physician / NP / PA Date Printed Name Physician or NP/PA