

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION (con't)

1. The preceding authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy if one was requested.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Name of Patient (Printed)	Signature of Patient	Date
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E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. 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) 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.

I authorize Bayshore Podiatry Center to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Bayshore Podiatry Center, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Bayshore Podiatry Center medical record.

Understanding all of the above, I hereby provide informed consent to Bayshore Podiatry Center 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.

This consent will remain enforce until revoked or changed.

Patient Name (PLEASE PRINT)

Signature _____ Date _____

4. **REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

5. **CANCELLED/MISSED APPOINTMENT FEE:** If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a \$50 fee for any appointment canceled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a \$50 fee if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.

6. Payment is due for rendered services 30 days from the date of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor. An additional \$35.00 will be added to your statement if the check is returned from your bank.

7. **COLLECTIONS FEE:** You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. There will be a \$10 re-billing fee acquired on your third notice. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

8. **PHYSICIAN PHONE CALLS:** Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

9. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of Florida. Fees must be received prior to record delivery. No more than 5 pages may be faxed.

10. **ADMINISTRATIVE SERVICES:** There is a \$25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

11. **NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS:** If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

12. **PATIENT REFUNDS** - Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

I, _____, have received, read, and understand the financial policy at Bayshore Podiatry Center.

Signature of Patient/Guardian

Date