Nancy E. Boyden, ARNP (NEB)

LASER-COSMETIC-WELLNESS CENTER

Patient Consents and Authorization Release

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 NEB's 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. Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

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

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.

Consent to Treatment

I hereby give my permission for NEB to provide me medical treatment. I allow NEB to file for insurance benefits, if applicable, to pay for the care that I do receive.

I understand that:

- NEB has the right to send my medical record information to my insurance company.
- I must pay my share of the costs.
- 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.

Consent to Cancellation Agreement

I understand that there may be a $75 charge for a missed appointment or late cancellation without 24 hours prior notice. Three missed non-cancellations in a row may result in a dismissal from the practice.

_____ Initial Here

7901 Skansie Avenue, Suite 105, Gig Harbor, WA 98335 Phone: (253)858-2408

OVER ➔

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations [§164.508(a)]

I understand that as part of my healthcare, NEB originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

Upon my request, I will be provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review NEB's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations [§164.506(a)]

I understand that:

- I have the right to review NEB's Notice of Information practices prior to signing this consent;
- NEB reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that NEB is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that NEB has already taken action in reliance thereon.

Patient Consent to Disclose Protected Health Information to Family and Friends

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on you prior consent.

☐ Do Not Disclose My Information to Anyone But Me
☐ You May Disclose My Information To The Following:

Name _____Relation to Patient: _____ Date:_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for NEB to use and disclose my protected Health Information (PHI) to perform treatment, payment and health operations. With this consent, NEB may text, call or email me and leave a message by text, voice, email or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results. With this consent, NEB may mail to my home or other alternative location any items that assist the practice in performing treatment, payment and healthcare operations such as appointment reminders, patient statements and anything pertaining to my clinical care. By signing this form, I am consenting to allow NEB to use and disclose my PHI to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that NEB has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, NEB may decline to provide treatment to me.

Printed Name of Patient:_____

Signature of Patient or Legal Guardian:_____Date:_____