AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize PCOS (Primary Care of Shelton, LLC) and Dr Bardia Asgari), its medical practices and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I understand the explanation(s) given and I acknowledge that no guarantee can be given to me by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for PCOS and I have access to this notice online at my discretion.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the PCOS provider of all service(s) furnished to me. I authorize PCOS to release any medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPAA release of protected health information standards. Further, I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to the PCOS provider of service(s). I hereby authorize the photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through PCOS medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an PCOS billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with PCOS's approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: I have been made aware and understand that the PCOS medical practice is using an Electronic Health Record. PCOS and the staff may share my health information to serve my medical needs. I further understand that my protected health information will remain secure as required by law.

ELECTRONIC PRESCRIBING: I have been made aware and understand that PCOS may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my PCOS and my pharmacy. I have been informed and understand that by PCOS using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to PCOS to see and verify this protected health information. I also allow PCOS to verify CT Prescription monitoring and Reporting System in compliance with the Connecticut controlled substance prescription practices.

IMMUNIZATION REGISTRY: I understand that PCOS participates in the Connecticut's Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.
PERMISSION TO FAX RETURN TO WORK: I do hereby grant permission for PCOS to send or fax Return to school/ Work records to school/work, upon request. I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

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PATIENT: DOB:

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Signature of Patient or Parent/Legal Guardian/Authorized Representative

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Relationship to Patient if Applicable

_____

Date