

Consent to Treatment

NERISSA S GUBALLA MD PC

I hereby give my permission for **NERISSA S GUBALLA MD PC** (the Practice) to give me medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.

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.

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.

Signature of Patient or Legal Guardian

Print Patient's Name: _____

**HIPAA Privacy Rule of Patient Authorization
Agreement**
**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, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or 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 and surgical 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.

I have been 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 this Practice'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.

Privacy Rule of Patient Consent Agreement
**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 this Practice's Notice of Information practices prior to signing this consent;
- that this Practice 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 this Practice 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 this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:

Print Patient's Name: _____

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.

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 my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Guardian

Print Patient's Name: _____

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.

Patient consent form

NERISSA S GUBALLA MD PC
Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for NERISSA S GUBALLA MD PC (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name: _____