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Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: STEPHANIE BRINEGAR **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: STEPHANIE BRINEGAR Date of Birth: 02/21/1981

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:**_____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

•Name:_____**Telephone:**_____**Relationship:**_____
Email::_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

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Controlled Substances Policy

We want to ensure that patients and caregivers have clear communication and safe, effective procedures for obtaining controlled substances when medically necessary. There are a variety of medications and therapies available to help individuals with both acute and chronic pain. Our health care providers strive to ensure that each individual gets the most appropriate treatment for the individual's diagnosis or condition. Our office uses the state designated monitoring resources, which allows our health care providers to request information regarding a patient's previously dispensed controlled substance prescriptions. This tool assists our health care providers in establishing the patient's treatment history and making treatment decisions.

In order to comply with state and federal laws, it is important that you, as a patient, understand and follow this **Controlled Substances Policy**. All patients must sign this informed consent.

(Please initial Each Line)

1. All requests for controlled substances prescriptions must be made during normal business hours. Please plan accordingly as we will not prescribe any controlled substances, including refill prescriptions, after hours. _____Initials

2. Federal, state and local laws and regulations may prohibit e-prescribing for certain controlled substances, if we are unable to e-prescribe, you will be responsible for picking up any controlled substance prescriptions at our office during normal business hours. You will be asked to present government- issued identification to verify your identity. _____Initials

3. In no event will controlled substances prescriptions be mailed to patients. _____Initials

4. If a prescription for controlled substances is lost or stolen, we will not reissue another prescription for controlled substances until your next fill due date at which time a determination by your health care provider in their sole discretion regarding the continued medical necessity of the controlled substances will be made. If your health care provider determines that controlled substances are no longer the most appropriate treatment option, they will not issue another prescription for controlled substances. _____Initials

5. If your condition or diagnosis requires an on-going prescription for controlled substances, you may need to see your health care provider at least every thirty (30) days and more frequently as may be determined by your health care provider in their sole discretion. _____Initials

6. If this practice is treating you for acute or chronic pain, it is important that we are the only prescribing health care providers for your condition. _____Initials

7. Our health care providers may lower the dose or decline to issue a controlled substances prescription at any time and may refer you for consultation with appropriate medical specialists in their sole discretion. _____Initials

8. As a condition of continued treatment by the practice, patients may be asked to submit to urine comprehensive drug screening or comparable alternative testing. Failure to comply with such requests for screening or screening results that indicate failure to comply with the prescribed dosage, multiple sources of controlled substances, or illegal or illicit drug usage may result in the patient being dismissed from the practice. _____Initials

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9. If it comes to our attention that another health care provider outside the practice, including a hospital or urgent care center, is prescribing controlled substances to you, you may be dismissed from the practice immediately at our sole discretion.
_____Initials
10. **For Females Only:** If I become pregnant while taking this medication, I will immediately inform my obstetrician and the physician prescribing the controlled substance to me. I will also obtain counseling on the risk to the baby.

I will submit urine and/or blood upon request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications and confirm the use of the prescribed ones. I will submit to pill counts without notice as per my physician's request. I will pay any portion of the cost associated with urine and blood testing that is not covered by my insurance. All requests for refills must be made by contacting the physician who is prescribing the controlled substance during business hours at least three (3) work days in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy which is authorized to release a record of my medications to this office upon request. A copy of the Agreement will be sent to my pharmacy.

Pharmacy Name/Address/Telephone:

_____

_____

_____

The daily dose may not be changed without the above-mentioned prescribing physician's consent. This includes either increasing or decreasing the daily dose.

Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.

Accidental destruction or loss of medication or prescription will not be a reason to refill medication or re-write prescriptions early. I will safe guard my controlled substance medication from use by my family members, children or other unauthorized persons.

You may be referred to an appropriate specialist to evaluate your physical condition.

You may be asked to have an evaluation by either a psychiatrist or a psychologist to help manager your medication needs.

If your physician determines that you are not a good candidate to continue with the medication, you may be referred to a detoxification program for evaluation by a pain management center.

Medications may be discontinued or adjusted at your physician's direction.

I understand that it is my physician's policy that all appointments must be kept or cancelled at least two working days in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit.

I understand that I am responsible for meeting the terms of this Agreement and that failure to do so will/may result in my discharge as a patient. Grounds for dismissal from your Provider's practice and Privia Medical Group include, but are not limited to,: evidence or recreational drug use, drug diversion, altering prescriptions (this may result in criminal prosecution), obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language toward staff, development of progressive tolerance, use of alcohol or intoxicants or engagement in criminal activities. _____Initials

I, _____, acknowledge that I have read and acknowledge the above information. I understand that failing to comply with the Controlled Substances Policy may cause a delay in receiving my controlled substances prescription (or future prescriptions for controlled substances) or discharge from the practice in the practice's sole discretion.

→ Signature: _____ Date: _____