ASSIGNMENT OF BENEFITS: FINANCIAL RESPONSIBILITY

Today's Date: _________________ MRN: __________________________

Full Patient Name: ____

DOB: _____________ Email: _______________________________ Preferred Language: _______________

Marital Status:
☐Married
☐Single
☐Divorced
☐Other

Ethnicity:
☐Hispanic
☐Non-Hispanic

Race:
☐American Indian
☐Native Hawaiian
☐Asian
☒White
☐Black/African American
☐Other _____________

Sex:
☐Female
☐Male
☐Other____________

Pronouns: ____________

Preferred telephone number: ____ ☐Cell ☐Work ☐Home

Home Address: ____

Patient Employer: ___________________________________Phone Number: _________________________

Employer Address: ______________________________________ Job Title __________________________

Responsible Party: ____________________ Relationship: _____________ Phone Number: _____________

Emergency Contact: __________________ Relationship: ______________Phone Number: _____________

Referring Physician: ____ Phone Number: _____________

Primary Care Physician: ____Phone Number: _____________

Primary Insurance: _________________Subscriber: _____________ Relationship to Patient: ___________
Subscriber Employer: __________Subscriber SSN: __________ Subscriber DOB: ___________
Group Number: ______________________ Policy number: _________________________________
Claims Address: ____ Phone Number: _____________

Secondary Insurance: _______________Subscriber: _____________ Relationship to Patient: ___________
Subscriber Employer: __________Subscriber SSN: __________ Subscriber DOB: ___________
Group Number: ______________________ Policy number: _________________________________
Claims Address: ____ Phone Number: _____________

Patient Signature: ____ Date: _____________________

Patient Representative Signature: ______________________________________ Date: _____________________

Wildflower Breast Center Representative Signature: _________________________Date: ____________________

WILDFLOWER
BREAST CENTER

Advanced Directives: This includes a Living Will, Medical Power of Attorney, and Out of Hospital Do Not Resuscitate order and allows you to state your choice in healthcare if you become unable to make decisions. Advanced directives are not required in order to receive proper medical treatment at this facility, but if you have executed advanced directives, you must provide a copy to us to be put in your medical chart to ensure that your wished are honored. If you are interested in learning more about advanced directives, ask your nursing professional for more information.

Please check at least one box:

☐I have a Durable Power of Attorney for Health Care.

☐I have a Living Will (directive to physicians)

☐I have an Out of Hospital **Do Not Resuscitate** directive. I understand I must wear an approval ID device or carry the original document in a visible manner in order for the document to be honored.

☐At this time, I have not executed any of the above directives and understand that in any emergency situation the medical staff will be responsible for making decisions regarding my care.

HIPPA Consent for Treatment, Payment, and other Healthcare operations

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of a non-payment, to assume the cost of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Wildflower Breast Center. I also authorize agents of any hospital treatment center and/or previous physicians to furnish Wildflower Breast Center copies of any records of my medical history, services or treatments. I also authorize the release of medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agreed to a review of my records for purposes of internal audits, research, and quality assurance reviews within Wildflower Breast Center.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing/physician services including major medical benefits are hereby assignment to Wildflower Breast Center. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legal binding assignment to collect my benefits as a payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Wildflower Breast Center.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and payors; (b) companies that produce chemotherapy and other drugs and clinical companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include sharing of patient identifying information such as my

WILDFLOWER BREAST CENTER

name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with Wildflower Breast Center.

5. I consent to the disclosure of my protected health information to any physician or facility that is currently or will be participating in my diagnosis, evaluation, treatment or follow-up care.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNTIL SUPERCEDED BY AN UPDATED AOB BY ME IN WRITING.

Patient Signature: ____ Date: _______________________

Patient Representative Signature: ____________________________ Date: _______________________

Wildflower Breast Center Representative Initials: ________________ Date: ______________________

CONTACT PERMISSION

Patient: ___________________ MRN: ________________ Date: _____________________

In the event that Wildflower Breast Center needs to contact you about your medical care but is unable to reach you directly, we would like to know if we are allowed to attempt any of the following commonly requested alternatives. Before you check one or more of the options below, please be mindful that these messages may include information about your test results, medications, insurance coverage, billing information, appointment details, or other personal information regarding your care at our practice.

If unable to contact me directly, I authorize Wildflower Breast Center to (please check the boxes you wish to include):

☐Leave a voicemail message at this phone number: _______________________

☐Speak to my spouse or significant other (name and relationship):

____

☐Speak to or leave a message with the individual listed below:

Name: ______________ Relationship: ___________ Phone Number: _____________

Name: ______________ Relationship: ___________ Phone Number: _____________

Name: ______________ Relationship: ___________ Phone Number: _____________

I understand that if I should decide to no longer authorize Wildflower Breast Center to share my information with any of the listed individuals listed above or leave a voicemail at the numbers indicated, that it will be my responsibility to notify the office in writing.

Patient Signature: ____ Date: _________________________

Patient Representative Signature: ______________________________ Date: _________________________

ACCIDENTAL EXPOSURES

Patient: ___________________ MRN: ________________ Date: _____________________

In the course of care and treatments, healthcare workers may be accidentally exposed to patient's blood or bodily fluid. Communicable diseases, including HIV virus that causes AIDS, are known to be transmitted through accidental exposures.

I understand that, in the event a healthcare worker is exposed to my blood or bodily fluids, my blood will be tested for the HIV antibody and other communicable diseases at no cost to me. My initials below signify that I understand the information and agree to your proposal.

On behalf of Wildflower Breast Center, we thank you for your cooperation.

Patient Initials: _________ Date: ______________

Pregnancy

Female patients, please let us know if there is any possibility that you may be pregnant.

☐Yes, ____

☐No

Patient Initials: _________ Date: ______________

E-PRESCRIBING CONSENT FORM

Patient: ____________________ MRN: _________________ Date: ______________________

E-Prescribing is defined as a physician's ability to electronically send an accurate error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Fill status notification- allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- Formulary and Benefits Transactions- Gives the prescriber information about which drugs are covered by 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.

By signing this consent form, you are agreeing that Wildflower Breast Center can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wildflower Breast Center to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature: ____ Date: _________________________

Patient Representative Signature: ______________________________ Date: _________________________

Pharmacy Information

Pharmacy Name: __________________________________Phone: ___________________

Pharmacy Address: ____

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF REVIEW

Patient: ___________________ MRN: ________________ Date of Birth: ______________

By checking the boxes below:

☐I acknowledge that Wildflower Breast Center had provided a copy of their Notice of Privacy Practices for review. Upon request, I may receive a copy their Notice of Privacy Practices for my personal records.

☐I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature: _______________________________________ Date: ________________________

Patient Representative Signature: ______________________________ Date: ________________________

Wildflower Breast Center Office Use Only

Date Acknowledgement received: ________________

Staff Signature: _______________________________________Date: ________________