Patient Consents:

**Prescription History Consent:**

1. I understand that the information obtained may include details about my current and past prescription medications, dosages, and refill information.
2. I acknowledge that this information will be used solely for the purpose of enhancing the quality of my healthcare and ensuring accurate medical records.
3. I consent to the disclosure of my prescription medication information to the medical professionals involved in my care.
4. I understand that this authorization will remain in effect until I provide written notification of revocation.
5. I acknowledge that I have the right to refuse or revoke this authorization at any time, but doing so might limit the effectiveness of my healthcare management.

This authorization form allows us access information about your prescription medications from an outside pharmacy for the purpose of your healthcare management. By signing the bottom of this form, you are providing your informed consent for this activity. \_\_\_\_\_\_\_\_\_Initial Here

**Telehealth Services Consent and Waiver:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to participate in telehealth services provided by Gainesville Family Practice, PC. I understand that telehealth involves the use of electronic communications to facilitate medical consultations, evaluations, and treatments. This form outlines my understanding of, and agreement to participate in telehealth services.

Telehealth Explanation:

1. Telehealth involves the use of audio, video, and other electronic communication methods to facilitate medical consultations. It allows for remote assessment, diagnosis, and treatment.
2. I understand that telehealth services may be used for medical evaluation, consultation, prescription management, follow-up appointments, and other healthcare-related activities.
3. Telehealth services may not be suitable for all medical conditions. My healthcare provider will determine the appropriateness of telehealth based on my medical needs.

Benefits and Risks:

1. Benefits of telehealth may include convenience, reduced travel, and access to medical care without physical presence.
2. Risks include potential technical issues, privacy breaches, and limitations in the provider's ability to conduct a physical examination.

Confidentiality:

1. I understand that my telehealth session will be conducted using secure and encrypted technology to protect the privacy of my medical information.
2. I will ensure that I am in a private and secure location during the telehealth session to maintain confidentiality.

Insurance and Payment:

1. I acknowledge that insurance coverage for telehealth services may vary. It is my responsibility to confirm coverage with my insurance provider.
2. I will be responsible for any copayments, deductibles, or other fees associated with the telehealth services.

Consent:

1. I voluntarily consent to participate in telehealth services and understand the potential benefits and risks associated with it.
2. I understand that my healthcare provider may determine that an in-person visit is necessary if my medical condition requires physical examination or intervention.
3. I agree to provide accurate and complete information during the telehealth session to facilitate proper medical evaluation and treatment.

By signing the bottom of this form, you are providing your informed consent to participate in telehealth services. Telehealth can provide convenient access to medical care, but it also comes with certain limitations and risks. Please consult with your healthcare provider if you have any questions or concerns about telehealth services or this consent form. \_\_\_\_\_\_\_\_\_Initial Here

**Authorized Information Sharing:**

I authorize the sharing of the following medical information:

* Medical history and records
* Diagnoses and treatment plans
* Laboratory results and imaging reports
* Medication lists and prescription details
* Allergies and adverse reactions

Purpose of Sharing:

This authorization is granted for the purpose of ensuring comprehensive and coordinated medical care between the authorized parties. I understand that the shared information will be used solely for my healthcare management and treatment.

**Duration of Authorization:**

This authorization will remain in effect until I provide written notification of revocation to the authorized parties listed above.

**Release of Liability:**

I release Gainesville Family Practice, PC and their respective healthcare providers and staff from any liability arising from the sharing of my medical information in good faith for the purpose of my healthcare.

By signing the bottom of this form, you are providing your informed consent for the authorized parties to share your medical information as described. This sharing of information aims to enhance the quality of your healthcare. If you have any questions or concerns about the information sharing process, please consult with your healthcare providers. \_\_\_\_\_\_\_\_\_Initial Here

**Notice of Receipt of Privacy Practices:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received and reviewed the Notice of Privacy Practices provided by Gainesville Family Practice, PC. I understand the importance of safeguarding my personal health information and maintaining my privacy rights in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

**Consent:**

By acknowledging receipt of the Notice of Privacy Practices, I acknowledge that I have had the opportunity to read and understand its contents. I also acknowledge that I am free to ask questions about the privacy practices at any time. \_\_\_\_\_\_\_\_\_Initial Here

**Patient Acceptance of Billing Assignment:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby assign and authorize Gainesville Family Practice, PC to bill and collect payments on my behalf for medical services rendered to me by the healthcare providers associated with the clinic. This assignment is made for the purpose of facilitating the billing and reimbursement process for my medical care.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge and accept responsibility for the financial aspects related to my medical care and treatment received at Gainesville Family Practice, PC. I understand that I am ultimately responsible for the charges incurred for the medical services provided to me.

Billing and Financial Responsibility:

I understand that medical services may include, but are not limited to, examinations, consultations, treatments, procedures, tests, and medications. I accept that I am responsible for any deductibles, copayments, coinsurance, and charges not covered by my insurance plan.

Insurance Coverage:

I acknowledge that I am responsible for providing accurate and up-to-date insurance information to Gainesville Family Practice, PC. I understand that any information regarding insurance coverage provided to me by my insurance company is not a guarantee of payment.

Communication and Questions:

I agree to promptly communicate with the billing department of Gainesville Family Practice, PC if I have any questions, concerns, or updates related to my insurance coverage or billing statements.

Authorization to Release Information:

I authorize Gainesville Family Practice, PC to release any necessary medical information and billing details to my insurance company or other third-party payer for the purpose of processing claims and determining benefits.

Consent:

By signing below, I acknowledge that I have read, understood, and agreed to the terms outlined in this acceptance of billing assignment. ­\_\_\_\_\_\_\_\_\_Initial Here

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_