PREMIUM WELLNESS
& PRIMARY CARE

Excellence. Every Patient. Every Time.

Authorization for Use and Disclosure of Protected Health Information

In general, the Health Insurance Portability and Accountability Act (HIPAA) privacy rules gives individuals the right to request a restriction on uses and disclosures of the protected health information and in keeping within the HIPAA guidelines this form is provided to you, the patient, to use as an official document giving Premium Wellness & Primary Care permission to send your health information to another party, or to receive it from another party. If you have any questions about managing how your information is shared, please contact a member of our care team.

PLEASE MAIL OR FAX RECORDS – NO DISC

I hereby authorize **Premium Wellness & Primary Care**, to receive my personal health information as identified below.

To: **Premium Wellness & Primary Care**
4002-C Spring Garden St
Greensboro, NC 27407
Fax: 336.553.0795

From: _____
_____
_____
_____

Please release this information for the following purpose(s):

I specifically authorize the use or disclosure of the following health information and records, if such records exist: Please Initial

_____ **All Medical Records** (Office notes, H&P, Specialist Reports, Imaging and Diagnostic, Lab Results, Pathology Reports)

_____ **Only the records specified here:** _____

Please initial the following items if you allow them to be included in the use or disclosure of your health information:

_____ HIV/AIDS related health information

_____ Drug & Alcohol diagnosis, treatment, or referral

_____ Mental Health related information

_____ Genetic testing information

_____ Psychotherapy notes (if this authorization is used for the release of psychotherapy notes, it cannot be combined with other information

I have read the following statements:

1. I understand that I may revoke this authorization at any time by notifying the practice in writing, but it will not affect actions that took place before I revoked the authorization.
2. I understand that if the entity that receives the information is not a healthcare provider or health care covered by federal privacy regulations, the information described above may be redisclosed by those entities and is no longer protected. Therefore, I release Premium Wellness & Primary Care, its employees, and my physician from all liability arising from this disclosure of my health information.
3. I understand that I may inspect, or request copies of any information disclosed by the authorization. It is my understanding that the authorization will expire in one year from the date signed below.
4. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

_____ _____ _____

Patient or Patient Representative's Signature **Patient or Patient Representative's Printed Name** **Date of Birth**

_____ _____

Witness's Signature **Witness's Printed Name**

Witness Signature **Date**

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HIPAA CONSENT FORM FOR THE USE / DISCLOUSRE OF PROTECTED HEALTH INFORMATION

Patient information will be maintained by Premium Wellness & Primary Care as directed by the Notice of Privacy Practices and in compliance with federal and state regulations. You may obtain a copy of the Notice of Privacy Practices by request at any time.

Premium Wellness & Primary Care reserves the right to release your healthcare information based on a decision by your physician for medical emergency situations and in general for continuity of care. We release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you select in writing to receive it.

We reserve the right to:

Call you to remind you of your next appointment and/or leave information about the appointment on your voicemail.

Please list the number(s) and e-mail that we can use to contact you:

Phone Numbers: _____

E-mail Addresses: _____

Authorization to Release Information:
Please list the person(s) in which you wish to authorize our facility to speak with, and the information you would like to either allow or keep restricted.

Name: _____

Relationship: _____ Allowed: _____ Restricted: _____

Information: _____ Purpose: _____

_____

Name: _____

Relationship: _____ Allowed: _____ Restricted: _____

Information: _____ Purpose: _____

_____

Please initial here if you prefer that no one have access to your records _____

I understand that my information will only be shared with my permission. I also understand that this release of information expires **(Date: _____)**, or with receipt of a new signed document.

Patient / Guardian Signature: _____ **Date of Birth:** _____

Printed Name (& Relation if not Patient) _____ **Date Signed:** _____

Witness Signature: _____ **Date:** _____

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APPOINTMENT CANCELLATION POLICY

Premium Wellness & Primary Care is committed to providing all our patients with quality individualized care in a timely manner. No Shows, late shows and cancellations prevents another patient from being seen.

We would like to remind you that effective **AUGUST 1, 2022,** our office will begin the **NO-SHOW POLICY** below:

1. All missed appointments, the patient will be notified by our office and reminded of our no-show policy. The appointment may be rescheduled.
2. If another scheduled appointment is missed, the patient will receive a letter in the mail regarding the missed appointment and a **$35** fee will be charged before the patient can be seen in the office or via telehealth.
3. After this, if another appointment is missed, the patient may be discharged from the practice. We will be available to treat you for 30 (days) on an **emergency basis** **only**, so that you can have access to care while searching for another physician.

No Show: A "*no-show*," is a patient who misses an appointment without cancelling the appointment 24 hours in advance or failure to be present at the time of a scheduled appointment. This includes arriving 15 minutes after your scheduled appointment.

Please call our office at 336-553-0793, 24 hours prior to the day of your scheduled appointment to notify us of any changes or cancellations. To Cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

You can also cancel appointments via the patient portal, with the same 24-hour cancellation notice. If you need access, please notify our office for a patient portal link.

Patient Signature: _____ **Date:** _____

Staff Member: _____ **Date:**_____

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4002- C Spring Garden Street
Greensboro, NC 27407
336.553.0793 (O) 336.553.0795 (F)

www.premiumwellnesspc.com

Effective Date of this Notice: October 16, 2016

Premium Wellness & Primary Care, PLLC

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, understand Premium Wellness & Primary Care's Notice of Privacy Practices, and would like to **receive / decline** a hard copy.

(Circle one)

_____ _____

Patient / Guardian / Parent Signature **Date**

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Medical Insurance Policy

- Premium Wellness & Primary Care will file your claim to your primary insurance, if you have more than one Insurance carrier, as a courtesy we will attempt to file a secondary claim, you must provide accurate insurance information at the time of service.
- A copy of your insurance card(s) is required to file your claim. Otherwise, you will be expected to pay in full up front for services rendered.
- If we are unable to verify your insurance coverage, you may be required to reschedule your appointment until we can contact someone.
- You may be allowed to be seen but will be required to pay for your visit in full, once we are able to file your claim and payment is received from your insurance company, we will reimburse any money owed.
- Co-payments, Co-Insurance, and Deductibles are collected in advance, unless prior arrangements have been made.
- We accept the following forms of payments: cash, checks, credit, or debit cards with the Logo: Visa, Master Card, America Express or Discover, HRA, HSA
- There will be a $25 service charge as well as the bank fee on all returned payments.
- Premium Wellness & Primary Care will try to accept assignment on the following Insurance companies; **Medicare Part B, Medicaid, Blue Cross and Blue Sheild, United Healthcare, Humana, Cigna, MedCost and Aetna.**
- HMO policies are subject to the policy requirements, which may or may not be able to be filed without prior authorization.
- **It is your responsibility to know your coverage.** You will be held responsible for all unpaid charges which may be subject to a 25% collection fee**.**

_____ _____

Patient / Guardian Signature Date

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E-Prescribing

E-Prescribing is a federally mandated Initiative that requires all physicians to prescribe in this manner by 2011.

E-Prescribing software sends prescriptions over the Internet to your pharmacy of choice in a safe secure way. Which helps to protect the privacy of your personal information.

E-Prescribing also allows your provider to see important information- like drug interactions and your prescription history.

Benefits as a patient include:

- Less confusion over handwritten prescriptions or unclear phone calls
- Possibilities for medical errors as well as adverse drug reactions are reduced
- Prescriptions are transmitted to the pharmacy, limiting the responsibility of the patient keeping up with paperwork
- A safe, fast, effortless way to get your prescription filled

Patient Consent to E-Prescribing

I agree that Premium Wellness & Primary Care may request and USE my prescription medication history from other health care providers or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Patient / Guardian Signature Date

PREMIUM WELLNESS
& PRIMARY CARE

Takela Anderson, DNP, MSN, FNP-BC

4002– C Spring Garden St, GSO, NC 27409

www.premiumwellnesspc.com

336.553.0793 (O)

336.553.0795 (F)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone #: _____ SS #: _____

At the request of the individual, I _____, do hereby authorize

Premium Wellness & Primary Care to release:

_____ **Healthcare information relating to the following treatment, condition, or dates Only (Specify below)**

_____

OR

_____ **All healthcare information**

For the past: 1 Year _____ 2 Years _____ 3 Years _____ 4 Years _____ ALL _____

Purpose of Disclosure: _____Change of Doctor_____ Continuity of Care _____ Legal Representation

_____ School _____Patient Request _____ Disability Determination _____ Other/Specify_____

Information released to: Name: _____ Fax #: _____

Address: _____

City, State, Zip: _____

I authorize the release of information related to the following:

_____HIV infection /AIDS _____Psychiatric Care _____Psychological Assessment _____ Treatment for alcohol / drug abuse

I hereby authorize disclosure of the health information for the above-named patient. I understand that I may revoke this consent at any time in writing and that this consent will expire on (Date: _____) or automatically expire in ninety (90) days from the date signed below. I also understand charges may occur and accept responsibility for reasonable copy fees charged by the office releasing records on my behalf pursuant to NC Law 90-411. I also understand that records from other health facilities should be obtained from the original source. This notice hereby releases the sender from any legal responsibility or liability for the release of information described in the release.

_____ _____

Signature (Patient / Guardian) **Date**