Feliz Care Centers

Consent form English

Consent to Obtain External Prescription History

I, (INT)_____, whose signature appears below, authorize Feliz Care Centers LLC and Its Affiliated Providers to view my external prescription history via the ePrescribing service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Consent to pay Benefits to Physician

I, (INT)_____, whose signature appears below, authorize direct payment to be made to the above named corporation. I understand Feliz Care Centers LLC will file an insurance claim on my behalf as a courtesy; nevertheless, I am financially responsible for the charges not covered by my insurance company. I also understand that if my account is not paid by myself or the insurance company after 90 days from the date of service, it will be turned over to an independent collection agency and a $25.00 fee will be added to the account for processing charges. There will be a $25.00 service charge for any returned check. I hereby certify that I do not have other insurance at this time.

Consent to Release information

I, (INT)_____, whose signature appears below, authorize Feliz Care Centers LLC to release any information required in the course of the patient's examination or treatment to insurance companies for payment. I hereby authorize any photocopies of this form to be valid as the original.

Consent to Release information to ASIIS

I, (INT)_____, whose signature appears below, authorize Feliz Care Centers LLC to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

Acknowledgement of receipt of Privacy Practices

I, (INT) _____, whose signature appears below, acknowledge that I have received a copy of Feliz Care Centers LLC "Notice of Privacy Practices." This notice describes how Feliz Care Centers LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected information.

HIE Acknowledgement of Patients Rights

I, (INT) _____, acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline a copy"

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient Name _____DOB_____

Patient Signature :_____Date:_____