CPHS | Carolina Personalized Health Solutions

Patient name_____DOB_____

Consent to Treat:

I hereby voluntarily consent to such services which may include comprehensive assessments, medical treatment, psychological testing, pharmacological management, behavior management, and emergency services by Carolina Personalized Health Solutions' Nurse Practitioner (NP) and the NP's designees as is necessary in his/her judgment. I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this medical practice**.**

I understand that by providing my consent for treatment Carolina Personalized Health Solutions will obtain my medication history information electronically through a pharmacy health information exchange (e.g., Surescripts, E-Prescribe). Clinicians access the information to know what medications I am taking so they can treat me appropriately and avoid adverse drug reactions.

Privacy:

I understand that information about me will be kept confidential in accordance with HIPAA. In understand that all records and information will be kept in my chart and shall not be released without my consent, or the consent of my authorized representative, except where the release is in accordance with applicable law. Disclosure may occur in certain circumstances in legal proceedings or to protect others or myself. I give CPHS permission to share records with and discuss my medical/psychological condition with my other caregivers, including, without limitation, staff of any facility where I reside, the hospital where I am hospitalized, or my day program, my attending physician, and other persons employed by CPHS involved in my care. I further authorize all notes, etc. written or composed by CPHS providers to be released to them upon request.

Pharmacy Health Information Exchange:

I consent to Carolina Personalized Health Solutions to obtain my medication history information electronically through a pharmacy health information exchange (e.g. Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to Carolina Personalized Health Solutions for any services furnished to me by their clinicians. I authorize my holder of medical information about me to release to the Centers for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Carolina Personalized Health Solutions for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient or Authorized Signature: _____

Relationship: _____ Date: _____ (Signed once in a lifetime)

Telephonic/Verbal authorization obtained from:_____

Signature of person obtaining telephonic/verbal consent:_____

Date consent obtained telephonically/verbally:_____