OAK MEDICAL CLINIC

Obstetrics and Gynecology

MEDICATION HISTORY CONSENT FORM

By signing this consent form, I give permission to Oak Medical Clinic to access my pharmacy benefits data electronically through RX HUB. This consent will enable Oak Medical Clinic to;

1. Determine the pharmacy benefits and drug co-pay for patient's health plan.
2. Check whether a prescribed medication is covered (under formulary) under patient's plan.
3. Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
4. Determine if patient's health plan allows electronic prescribing to mail orders pharmacies.
5. Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask you permission to obtain formulary information, and information regarding other prescriptions prescribed by other providers using RX HUB.

CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct
[Print Patient's Name] /[DOB]

OAK MEDICAL CLINIC and my treating health care provider, the employed and/or contracted medical personnel of OAK MEDICAL CLINIC as deemed necessary by my treating physician to perform a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from OAK MEDICAL CLINIC in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider employed by and/or contracted with OAK MEDICAL CLINIC unless I revoke this consent in writing by hand delivering a copy of the revocation to OAK MEDICAL CLINIC. By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

_____

Name/Signature of Patient Date

_____

Legal Guardian Name/Signature Date

_____

Witness Signature Date

_____

Provider Signature Date

OAK MEDICAL CLINIC

Obstetrics and Gynecology

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures, tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or his/her assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I understand that Alex Rojas, M.D. LLC may include this consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Alex Rojas, M.D. LLC will use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy or scan documents of this consent shall be considered as valid as the original.

MEDICAID/MEDICARE PATIENTS

I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my claims. I assign the benefits payable for services to Alex Rojas, M.D. LLC.

I acknowledge that I have been given the Notice of Privacy Practices by Dr. Alex Rojas, M.D. LLC. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

RELEASE OF INFORMATION AND ASSIGNEMENT OF BENEFITS

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to **ALEX ROJAS, M.D. LLC**. I authorize any holder of medical information about me to release to my insurance and their agents any information needed to determine these benefits or the benefits payable for related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. **ALEX ROJAS, M.D. LLC** the charge determination of the insurance carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier. If for any reason the insurance company does not honor their contract and payment is not forthcoming or if the insurance company does not pay the entire claim, then I will be responsible for the full or remaining balance.

Medicare, (under Section 1862 (a)(1) of the Medicare law), and some health insurance plans will only pay for services that deems to be "reasonable and necessary". If Medicare determines that a service is not reasonable or necessary or my insurance company determines that service was not authorized or not covered under my plan, Medicare or my insurance company will deny payment. Payment then will be my responsibility.

I understand that I am financially responsible for *any balance not covered by my insurance carrier, and after all applicable adjustment per insurance contract has been applied*.

I CERTIFIED THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE NOTIFICATION.

I have read, understand, and agree to the information described. By reviewing this form, I agree that I have been given the opportunity to ask questions about this document and that my questions have been answered to my satisfaction.

_____

Name/Signature of Patient Date

_____

Legal Guardian Name/Signature Date

Oak Medical Clinic

Obstetrics and Gynecology

Patient Registration Information

Personal Information Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name:_____DOB:_____Age:_____SSN:_____

Address:_____
Street City State ZIP

Phone:_____EMAIL:_____Primary Language:_____

RACE: WHITE:____ BLACK:____ ASIAN:____ OTHER:_____ ETHNICITY: HISP_____ NON-HISP _____ Refuse to report: ____

Primary Doctor:_____Phone:_____Do not have a Primary Doctor __

Pharmacy (Name and Address)_____Phone:_____Fax:_____

Insurance Information

Primary Insurance Company_____ **Is This You Only Insurance Policy?** Yes ☐ No ☐

Policy Holder's Name:_____DOB: _____

SSN:_____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy ID:_____Group Name/No: _____

Secondary Insurance Company _____

Policy Holder's Name:_____DOB: _____

SSN:_____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy ID:_____Group Name/No: _____

Responsible Party Information **Legal Guardian** ☐

Name:_____DOB:_____Phone:_____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other_____

Emergency Contact Information

Name: _____ Relationship _____ Phone:_____

Is this emergency contact able to receive personal information for HIPPA purposes? ☐ **Yes** ☐ **No**

REASON FOR CONSULTATION: (__) ANNUAL (__) ABN.BLEEDING (__)DISCHARGE (__)BREAST LUMP (__)INFERTILITY (__)PELVIC PAIN (__)PREGNANCY (__)OTHER:_____

_____ _____
Signature Date

_____ _____
Legal Guardian Name/ Signature Date