*WELCOME TO THE PRACTICE!*

*MON VALLEY PRIMARY CARE*
*2 EAST GATE AVENUE SUITE 101 MONESSEN, PA 15062*

DATE: _____

PATIENT'S LAST NAME: _____ PATIENT'S FIRST: _____

MARITAL STATUS: _____ FORMER NAME: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

ADDRESS: _____

PHONE: _____ ALTERNATE PHONE NUMBER: _____

SS# _____ EMPLOYER: _____

RACE: (Please circle) Caucasian American Indian or Alaska Native Asian

Native Hawaiian or Other Pacific Islander African American Hispanic or Latino Other

ETHNICITY: Hispanic or Latino Not Hispanic or Latino Unreported / Refused to report

Gross Annual Income: _____ ☐ Do not wish to provide

Number of dependents: _____

Veteran / Nonveteran status: _____ E-MAIL ADDRESS: _____

**INSURANCE INFORMATION:**

PERSON RESPONSIBLE FOR BILL: _____ DOB: _____
RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
PHONE NUMBER: _____ EMPLOYER: _____

INSURANCE PLAN NAME: _____
POLICY NUMBER: _____ GROUP #: _____
INSURANCE SUBSCRIBER'S NAME: _____ DOB: _____
SUBSCRIBER'S S.S. NUMBER: _____
PATIENT'S RELATIONSHIP TO THE SUBSCRIBER: _____

Is this patient covered by another insurance plan? _____ Name of Plan: _____

**IN CASE OF EMERGENCY:**

NAME OF RELATIVE/FRIEND NOT LIVING WITH YOU: _____
RELATIONSHIP TO PATIENT: _____ PHONE: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to MVCHS, Primary Care for any and all services rendered to me. I understand that I am financially responsible for any balance in full within twenty-eight days of receipt of billing. I also authorize MVCHS, Primary Care Inc. or insurance company to release my information required to process my claims.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

*MON VALLEY COMMUNITY HEALTH SERVICES, INC.*
*PRIMARY CARE*
*2 EAST GATE AVENUE MONESSEN, PA 15062*

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Mon Valley Community Health Services, Inc can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefits payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Mon Valley Community Health Services, Inc. to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Printed Patient Name Today's Date

_____ _____

Signature of patient/guardian Patient DOB

_____

Relationship to patient

*Mon Valley Community Health Services, Inc.*
*Primary Care - Receipt of Notice of Privacy Practices*
*2 East Gate Avenue Monessen, PA 15062*

Print your name _____ Date of Birth _____

Address _____

I have reviewed and have been offered a copy of the Mon Valley Community Health Services, Inc. Notice of Privacy Practices.

Signature of patient or guardian if a minor _____ Today's Date _____

By placing my initials I authorize the following persons to receive information regarding me. _____

☐ No One ☐ Spouse ☐ Parents ☐ Other (see below)

First Name _____ Last Name _____ Relationship _____

First Name _____ Last Name _____ Relationship _____

Description of information that I authorize to be released (check all that apply):

☐ Any and all information related to my care and financial standing at Mon Valley Community Health Services

☐ Financial, billing, and insurance information

☐ Any and all medical information including reasons for tests, etc.

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed by will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by Federal or State law.

I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to the Privacy Office, Mon Valley Community Health Services, Inc. 2 East Gate Avenue, Monessen, PA 15062. I understand that my treatment will not be conditioned on signing this authorization. I understand I have the right to refuse to sign this authorization.

Signature of patient or guardian if a minor _____ Today's Date _____