Regional Primary Care, Inc.
150 S. Mt. Auburn Rd., Ste. 418
Cape Girardeau, MO 63703
(573)332-6000

J. Christopher Bauer, M.D.
Christopher M. Compton, M.D.
S. Kent Griffith, M.D.
Mark C. Kasten, M.D.
I. Scott Taylor, D.O.
John V. Earnhart, M.D.
Amy Calice, FNP
Angela C. Compton, CS, FNP
Emily Greenley, FNP

Patient Name: _____ DOB: _____/_____/_____

CONSENT FOR CARE

I give consent to Regional Primary Care to furnish medical care and treatment to me. **INITIALS_____**

ASSIGNMENT OF BENEFITS AND FINANCIAL CONSENT

I agree to assign all medical/surgical benefits to which I am entitled to Regional Primary Care; including Medicare, Medicaid, private insurance, and any other health plans or payer sources. I authorize all insurance companies, Medicare, Medicaid, other medical providers, and any other entity having information concerning my care to release this information to Regional Primary Care for treatment and payment purposes. I understand that my insurance will be billed as a courtesy to me, but that the ultimate responsibility of payment for services rendered is mine. Should I allow the account to become delinquent, I will be responsible for any further collection costs including fees of a collection agency, attorney, or court costs.

INITIALS_____

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby give consent for Regional Primary Care to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by Regional Primary Care describes such uses and disclosures more completely. I understand that I have the right to review the notice prior to signing this consent. Regional Primary Care reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to Regional Primary Care.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.
4. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.
5. If I do not sign this consent or later revoke it, Regional Primary Care may decline to provide treatment to me.
6. This consent will remain in effect until terminated by me in writing. **INITIALS_____**

RELEASE OF INFORMATION

I give permission for Regional Primary Care to discuss my medical information with and/or allow access to my medical records to the following:

- ☐ Spouse: _____
- ☐ Children: _____
  _____
  _____
  _____
- ☐ Other: _____ Relationship: _____
  _____ Relationship: _____

TELEPHONE MESSAGES

I understand that Regional Primary Care will call my provided contact number(s) and leave a message on voice mail or in person in reference to appointment reminders. I may request in writing that this service be discontinued.

I understand that Regional Primary Care may also call my provided contact number(s) and leave a message on voice mail or in person in reference to insurance items and items related to my clinical care such as test results, medication information, responses to medical questions, among others. For these calls I give permission for Regional Primary Care to:

- ☐ Leave a message at my provided contact number(s).
- ☐ Leave a *brief* message at my provided contact number(s) asking me to return your call.

MEDICATION HISTORY CONSENT

For medication clarification, I authorize Regional Primary Care, Inc. to electronically obtain my medication history from my pharmacy(s) if needed.

- ☐ Granted by Patient
- ☐ Granted by Parent/Guardian
- ☐ Denied

_____ _____ _____/_____/_____

Patient (or Legal Guardian) Signature **Relationship** **Date**