CARDIOVASCULAR CONSULTANTS HEART CENTER

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PBM Hx CONSENT

We are updating your consent preferences in our system. **PBM Hx** consent is to allow your provider to review your medications electronically from your pharmacy benefits, which improves the accuracy of your medication list in your electronic chart.

Print Name: _____

(PLEASE PRINT CLEARLY)

Date of Birth: _____

Permission to review my Rx History electronically: ☐ **YES** ☐ **NO**

Signature: _____ Date: _____

I have read the above information and have verified it to be correct.

PBM Hx = Pharmacy Benefit Manager (PBM) History. If you have an Rx Benefit Plan the system will download the medication history from the Pharmacy Benefit Manager (PBM) for your doctor to review your medications.

Notice of Privacy Practices (HIPAA)

This notice is for **Privacy Practices** informing you that we will send documents such as test results and letters regarding your health care provided by CVCHC to your primary care and referring providers. **We will not share your personal health information for any other reason without written consent from you**.

Cardiovascular Consultants Heart Center has made available to me their Notice of Privacy Practices. I am aware that I have the right to a paper copy of this notice.

Signature: _____ Date: _____

I have read the above information and have verified it to be correct.

HIPAA = **HIPAA** (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information.

Financial Policy

I hereby authorize my insurance benefits to be paid directly to Cardiovascular Consultants of Fresno. I understand that I am financially responsible for all services not covered by my insurance company, which includes my annual deductible.

***If you are an HMO patient, also read and initial this statement:** I am aware that if Cardiovascular Consultants does not receive a referral from my primary care doctor all charges will be my responsibility. *_____ **(Initials)**

Signature: _____ Date: _____

I have read the above information and have verified it to be correct.

This signed document will be scanned to Patient Information in the electronic chart.

(Financial Office Use Only: ☐ **Scanned To Chart)**