Jefferson Regional

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful.

REGARDING INSURANCE
We bill insurance as a courtesy to our patients. The balance is your responsibility whether your insurance pays or not. It is your responsibility to give us your accurate and up to date insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not accept assignment of benefits we require that you pay up front for the non-covered portion. Please be aware that some of the services provided may be non-covered and/or not considered reasonable and necessary under the Medicare program and/or other medical insurance and will be your responsibility.

SELF PAY PATIENTS
Payment in full is due at the time service is rendered unless prior arrangements have been made.

Please understand that your bill is considered a part of your treatment. In order to provide service to all of our patients, timely payment is considered crucial. Unless prior arrangements have been made we will refer your account to a collection agency after 120 days.

I understand and agree to the above financial policy and hereby authorize Jefferson Hospital Association and rendering practices permission for treatment and to file my insurance for services.

DELINQUENT ACCOUNTS
I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Jefferson Hospital Association and rendering practices when they accept assignment.

CONSENT FOR TREATMENT
I hereby authorize the attending physician and/or medical staff at Jefferson Hospital Association and rendering practices to render any necessary professional services including examination, treatment and ancillary services.

CONSENT TO PHOTOGRAPH
I understand that photographs, videotapes, digital or other images may be recorded to document my care and I consent to this. I understand that JRMC will retain the ownership rights to these photographs, videotapes, digital and other images but I will be allowed to view them or obtain copies. I understand these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in JRMC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

EPRESCRIBING CONSENT

ePrescribing 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. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

FORMULARY AND BENEFIT TRANSACTIONS - Give 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, you are agreeing that JRMC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I hereby provide informed consent to JRMC to enroll me in the ePrescribe program. I understand all of the above. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

HIPAA COMPLIANCE

I attest I have received a copy of Jefferson Hospital Association and rendering practices compliance with regards to the Health Insurance Portability and Accountability Act.

Cardiology Associates
Healthworks
Endocrinology of South Arkansas
GI Associates
Children's Clinic of Southeast Arkansas
JRMC Neurology
OB/GYN Associates of South Arkansas
Pine Bluff Specialty Clinic
South Arkansas Orthopaedic Center
Surgical Associates of Southeast Ark
Family Health Associates of Southeast Arkansas.
Jefferson Regional Cancer Center
Urgent Care Clinic

Printed Name: _____

Patient Signature: _____

Date: _____

JEFFERSON REGIONAL MEDICAL CENTER COVID-19 IMMUNIZATION CONSENT FORM

Date of Vaccination:

Person Receiving Vaccine:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

**If YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration*	***YES**	**NO**
Are you feeling sick today?	☐	☐
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product	☐	☐
Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen® or for which you had to go to the hospital?	☐	☐
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐	☐
Are you pregnant, breastfeeding or plan to becoming pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.	☐	☐
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.	☐	☐
Have you received another vaccine in the last 14 days?	☐	☐
Have you had a positive test for COVID-19 in the last 14 days or has a doctor ever told you that you had COVID-19?	☐	☐
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐
Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
• **NOTE:** A second dose of COVID-19 vaccine **may** be due in 21 days to 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days to 28 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.	☐	☐

PLEASE SIGN THE BACK OF THIS PAGE.

2. **RELEASE AND ASSIGNMENT.**
Please read the section below.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian:

_____Date_____

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com to view current EUA: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.**
- **I give consent to this COVID-19 provider/staff for the individual named above to be vaccinated with COVID-19 vaccine.**
- **I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to this COVID-19 Provider.**
- **I agree that the authorization will cover all medical services rendered until I revoke the authorization.**
- **I agree that the photocopy of this form may be used instead of the original.**