Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to **Magic Valley Foot & Ankle** for medical or surgical services or items rendered to me or my dependent by **Magic Valley Foot & Ankle**. Should my insurance carrier deny Magic Valley Foot & Ankle payment, I understand that I am financially responsible for the charges. I authorize **Magic Valley Foot & Ankle** to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. I am also acknowledging that I had the opportunity to receive a copy of the "Notice of Privacy Practices" and that I have read (or had the opportunity to read if I so choose) and understand the notice

Please sign below that you read/understand the above statement.

_____

Signature Date

_____

Patient Name (please print) Authorized Representative (If Applicable)

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program. ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

• Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at the practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this

consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to the practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Signature Date

_____

Patient Name (please print) Authorized Representative (If Applicable)