PASTEUR MEDICAL ASSOCIATES, P.A.

INTERNAL MEDICINE

4410 Medical Drive, Suite #100 • San Antonio, Texas 78229 • Phone: 210-614-4000 • Fax: 210-614-9114

Bradley B. Kayser, MD ◆Michelle C. Scanlan, MD ◆Hoan Q. Pho, MD ◆Robert B. Goff, MD ◆John P. Galan, MD ◆ Brenda B. McMahon, MD

PLEASE PRINT CLEARLY DATE: _____ ACCOUNT NUMBER: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State _____ Zip: _____

Home/Work Phone: _____ Cell Phone: _____

Sex: Male/ Female **Social Security#** _____ **Marital Status:** S M W SEP D

Race: _____ Ethnic Group: _____ Preferred Language: _____

Patient Employed By: _____ Occupation: _____ Phone: _____

EMAIL (personal only): _____

IN CASE OF AN EMERGENCY CONTACT: _____ Phone# _____ Cell# _____

ALLERGIES: _____

Pharmacy: _____ Pharmacy Phone: _____

Referred By: _____ Former Physician: _____

INSURANCE

Do You Have Medicare? Yes No Do You Have Medicaid? Yes No

#1) Primary Insurance Name: _____ Group# _____

ID# _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Subscriber's Employer: _____

#2) Secondary Insurance Name: _____ Group# _____

ID# _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Subscriber's Employer: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits of _____ (Insurance Company Name) to Dr. _____ for services rendered.

I authorize the release of any medical or other information necessary to process my medical insurance. I also request payment of government benefits to the party who accepts assignment, or to myself for non-assigned claims. This authorization applies to all occasions of service until it is revoked. The undersigned does hereby give authorization to the physician to administer such medication and perform such procedures as maybe necessary for the best care of the patient. The undersigned also does hereby give authorization for Pasteur Medical Associates to web-enable your personal e-mail, thus allowing e-mail notification of passwords and patient portal notifications.

_____

Patient Signature and Date

SERVICES ARE PAYABLE WHEN RENDERED

PASTEUR MEDICAL ASSOCIATES, P.A.
4410 MEDICAL DRIVE, SUITE 100
SAN ANTONIO, TEXAS 78229
210-614-4000 210-616-0449

NOTICE OF PRIVACY PRACTICES

Effective Date: **July 15th, 2013**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:

Anna Talamantes at 210-614-4000

WHO WILL FOLLOW THIS NOTICE?

- Bradley B. Kayser, MD, John P. Galan, MD, Hoan Q. Pho, MD, Michelle C. Scanlan, MD, Brenda B. McMahon, MD, Robert B. Goff, MD
- Pasteur Medical Associates, P.A. providers
- All Pasteur Medical Associates, P.A. employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Pasteur Medical Associates, P.A, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Pasteur Medical Associates, P.A. shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Pasteur Medical Associates, P.A. will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Pasteur Medical Associates, P.A. in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.

- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Pasteur Medical Associates, P.A. may provide a written, telephone reminder, e-mail reminder that your next appointment with Bradley B. Kayser, MD, John P. Galan, MD, Hoan Q. Pho, MD, Michelle C. Scanlan, MD, Brenda B. McMahon, MD, Robert B. Goff, MD, is coming up.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:

    - To prevent or control disease, injury, or disability;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

    - In response to a court order or subpoena; or
    - If Pasteur Medical Associates, P.A. determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

- **Electronic Disclosure.** Texas law requires that we provide you with notice that your PHI is subject to electronic disclosure. Please note that we may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider

providing your treatment requests a copy of your medical record, we may forward such record electronically.

- **Marketing.** Marketing generally includes a communication made to describe a health related product or service that may encourage you to purchase or use the product or service. For example, marketing includes communications to you about new state-of-the-art equipment if the equipment manufacturer pays us to send the communication to you. We will obtain your written authorization to use and disclose PHI for marketing purposes unless the communication is made face to face, involves a promotional gift of nominal value, or otherwise permitted by law.

All other uses and disclosures of your information for marketing purposes require your written authorization.

- **Sale of your Medical Information.** Pasteur Medical Associates, P.A. will not sell your medical information for marketing purposes. However, there are instances in which Pasteur Medical Associates; P.A. may disclose PHI in exchange for remuneration to another covered entity for treatment, payment, or certain health care operations. For example, should Pasteur Medical Associates, P.A. merge or the practice is sold to another physician group, your medical record may be part of the asset transfer.

Any other sale of Protected Health Information requires your written authorization.

- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Pasteur Medical Associates, P.A. If you request a copy of the information, Pasteur Medical Associates, P.A. may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

Pasteur Medical Associates, P.A. may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Pasteur Medical Associates, P.A. will review your request and denial. The person conducting the review will not be the person who denied your request. Pasteur Medical Associates, P.A. will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Pasteur Medical Associates, P.A. to amend the information. You have the right to request an amendment for as long as the information is kept by Pasteur Medical Associates, P.A.

  To request an amendment, your request must be made in writing and submitted to Pasteur Medical Associates, P. A. In addition, you must provide a reason that supports your request.

  Pasteur Medical Associates, P.A. may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Pasteur Medical Associates, P.A. may deny your request if you ask us to amend information that:

  - Was not created by Pasteur Medical Associates, P.A., unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Pasteur Medical Associates, P.A.;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** To request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to Anna Talamantes, Privacy Officer. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Pasteur Medical Associates, P.A. will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Pasteur Medical Associates, P.A. uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Pasteur Medical Associates P.A. discloses about you to someone who is involved in your care or the payment for your care.

Pasteur Medical Associates, P.A is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Pasteur Medical Associates, P.A. has been paid out of pocket in full. Should Pasteur Medical Associates, P.A. agree to your request, Pasteur Medical Associates, P.A. will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to Pasteur Medical Associates, P.A. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Pasteur Medical Associates, P.A.'s use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Pasteur Medical Associates, P.A. communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Pasteur Medical Associates, P.A. contact you only at work or by mail.

  To request that Pasteur Medical Associates, P.A. communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Pasteur Medical Associates, P.A. will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Revoke an Authorization.** There are certain types of uses or disclosures that require your express authorization. For example, Pasteur Medical Associates, P.A. may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting Anna Talamantes at 4410 Medical Drive, Suite 100, San Antonio, Texas 78229. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.
- **Right to Receive a Copy of this Document.** You have a right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Pasteur Medical Associates, P.A. or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Pasteur Medical Associates, P.A., contact the Privacy Officer at 210-614-4000. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that Pasteur Medical Associates, P.A. has provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature Relationship to Patient

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PMA FINANCIAL POLICY STATEMENT

Recent changes in healthcare have made it necessary for Pasteur Medical Associates (PMA) to implement changes in our Financial Policies. Our main goal is to provide quality medical care in the most cost-effective manner possible to our patients.

1) Payment will be expected at time of service, for all deductibles, co-insurances and co-pays. These fees are only an estimate determined by the information provided to us by your insurance company and not a guarantee of payment. If your insurance does not cover all of the services provided; you will be responsible for any balance due.

2) All current insurance information must be presented prior to services so that benefits can be verified and to facilitate the filing of your claim. We will also ask you to present a photo ID, this is required under Federal Law, to prevent fraud.

3) Insurance benefits and coverage is a contract between you and your insurance company. Thus, it is ultimately your responsibility to know what your benefits are. It is also patient responsibility to notify the physician at time of service that you will be utilizing your preventive care benefits. Once a claim has been filed to the insurance no changes will be made.

4) Patients will assume responsibility for all claims not paid by insurance within 90 days. As such, it is important that you respond prompt to any inquiries from your insurance or PMA.

5) Please notify the office of appointment cancellations 24 hours in advance. Otherwise a **No Show Fee** will be charged. Any questions please ask Office Staff.

6) There is a $35 service charge for any check returned as insufficient funds.

7) There will be a fee for any forms filled out/signed by the physician. Payment for forms Filled out/signed is due at the time you retrieve the completed forms.

8) Please be advised if your insurance requires that you use a specific lab outside of ours. It is the patient's responsibility to notify the Medical Assistant PRIOR to blood being drawn. The medical assistant will gladly issue you a written request for labs to be drawn elsewhere. If you do NOT notify the assistant prior to blood being drawn all lab charges will be patient responsibility.

9) PMA will make every effort to acquire accurate insurance verification from your insurance. As a service to you we will file your claims to the insurance information you provide. Should the information provided be invalid or expired, you will be responsible for payment.

10) Should any overpayment occur PMA will directly issue a refund.

11) PMA will file claims to no more than 2 insurance companies. Any additional insurance filings will be patient responsibility.

12) PMA will file your claim at least twice. If we have not heard from your insurance company within 90 days we will send the bill to you and it will be your responsibility to contact your insurance and assume payment. State Law requires insurance companies to pay most claims within 30-45 days of being submitted.

13) Our goal is to assist you in receiving the coverage to which you are entitled. To that end PMA take's great care in filing claims promptly (usually within 48 hours) and accurately, with the necessary codes for services rendered.

14) **Addendum Effective: March 1st, 2011**
Regarding: Treatment Over the Phone, Phone Calls and After Hours Prescription Refill Charges.
This notice serves as an acknowledgement that our office has a new policy regarding Physician phone calls, treatment (s) over the phone and Prescription refills after hours. These policies are intended to help our office run efficiently while maintaining a high level of quality care to our valued patients.

- **Prescription Refills After Hours**: We have issued a policy to all patients reviewing our refill process. If you have not received a copy please ask the front office staff for a copy. We ask that you allow 48 hours for a refill during regular weekday hours. After hours requests and written prescriptions take a longer time frame. Routine prescriptions should be refilled by your personal physician.

Continued.....

Prescriptions written by other physicians/ or specialist should be refilled by that original physician unless expressly allowed by your physician at PMA. If you call and request a refill after our office has closed and on weekends a charge of $30.00 dollars will be incurred for this service. This will not be billed to any third party and will be the patient's sole responsibility.

- **Treatment Over the Phone**: We strongly encourage you to be seen and not treated over the phone. In the event that extenuating circumstances prevents you from being evaluated and we can safely treat you over the phone, a charge will be billed for this service. The charge will range from $30.00 to $80.00 dollars depending on the length of time spent on the phone and the complexity of the issue discussed. This charge will not be billed to any third party, and will be the patient's sole responsibility. The physician on call after office hours and on weekends will determine if it is safe to treat over the phone or if you need to go to the ER or if you can wait to be seen by your physician or associate during regular office hours. Treatment may or may not require a prescription called into the pharmacy.
- **Phone Call**: Often physicians receive calls after hours and weekends from patients to consult with them on medical issues. You may be charged $30.00 to $80.00 for this phone consultation depending on the length of time spent on the phone and the complexity of the issues discussed. This will not be billed to any third party and will be the patient's sole responsibility.

16) Addendum Effective: January 01, 2012

- **Medical Record Release and Billing History Fee's.**

Medical Record Release Fee will be $25.00 for the first 20 pages and $.50 per copy page thereafter. Records will be released within 15 days of written request as long as Record Release Fee has been paid. Non-payment of Fee may result in Medical Records being retained for payment.
Billing History fee is $15.00.
(Reference: Texas Medical Board Rules; Administrative Code, Title 22, Part 9, Chapter 165)

I have read, understand and agree to accept the office Financial Policies described above as set forth by PMA. I also understand and agree that these policies may be amended by the practice at any time. The practice will make every effort to notify patients of any changes.
We appreciate your loyalty to our practice, and please know that we strive to offer the highest of quality care to our patients.

Thank You,

_____	_____ _____	_____
Signature	Please Print Name	Date

Policies effective 9/1/2010
Amended effective 12/30/10
Updated fee's 01/01/2012

PASTEUR MEDICAL ASSOCIATES, P. A.
INTERNAL MEDICINE
4410 Medical Drive, SUITE 100
SAN ANTONIO, TEXAS 78229
210-614-4000 FAX 210-616-0449

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use of disclosure of information from the medical record of:
Patient Name _____ Account # _____
Date of Birth _____ Social Security # _____

I authorize the following individual or organization to disclose the above named individual's health information:
_____ Address: _____
This information may be disclosed TO and used by the following individual or organization:
_____ Address: _____
For the purpose of: _____
Please release the following:

_____ Problem List
_____ Progress Notes
_____ History /Physical Exam
_____ Medication List
_____ Immunization Record
_____ Other Diagnostic Reports (Specify) _____
_____ X-Ray/Imaging Reports-from (date) _____ to _____
_____ X-Ray Films
_____ Laboratory Results-from (date) _____ to _____
_____ EKG Reports
_____ List of Allergies

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
_____ **Yes,** I consent to the release of this information _____ **NO,** I do not consent

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Anna Talamantes.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold **Pasteur Medical Associates, P.A.** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed _____ #Pages copied _____ Reviewed only _____
Charges $ _____ Cash _____ Check # _____ Initials _____

Filling Your Prescription

Just Got Quicker and Easier

Our office has switched to electronic prescribing, also called "e-prescribing." That means we will send your prescription to your pharmacy via a computer or handheld device.

Keep in mind, your prescription may not always be ready as soon as you arrive at the pharmacy. Occasionally, you may still receive a paper prescription because electronic transmission of prescriptions for certain drugs, such as narcotics, is prohibited by the DEA.

Tell us where you'd like your e-prescription sent: Use the form below to tell us which pharmacy you'd like your prescription sent to. Not sure where it's located? Provide the nearest cross streets, or we can suggest a pharmacy close to this practice.

We will always confirm which pharmacy you'd like to use before your prescription is sent electronically. This information will help speed the process.

E-Prescriptions are:

- ✔ **Fast:** Your prescription is sent to your pharmacy before you leave our office.
- ✔ **Convenient:** There is no need for an extra trip to the pharmacy to drop off your paper prescription.
- ✔ **Legible:** There is no handwriting for the pharmacist to interpret. Instead, you get a printed receipt with your prescription and pharmacy details.
- ✔ **Secure:** E-prescriptions are sent through a private, secure network — not over the Internet or by e-mail.

Primary Pharmacy _____

Address _____

City, State, Zip _____

Phone _____

Secondary Pharmacy _____

Address _____

City, State, Zip _____

Phone _____

E-prescriptions will soon be the standard for how medicine is prescribed nationwide. If you have any other questions, just ask us. Or visit

www.learnaboutepresc riptions.com.

Pastuer Medical Associates, P.A.

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Michelle C. Scanlan, M.D. **Brenda B. McMahon, M.D.**

Authorization for Release of Diagnostic Reports

On Answering Machine

I authorize Dr. _____ and medical assistant to leave diagnostic test results pertaining to _____ on (check all that apply):

___ Home answering machine

___ Cell phone voice mail

___ **I prefer to have no messages left on my voice mail or answering machine**

Specific Diagnostic test(s) results: _____

_____

_____

_____

_____

Patient Signature

_____

Date

Pasteur Medical Associates, P.A.
Medication List

Please list ALL medications you are currently taking (including birth control pills, vitamins, aspirin, ibuprofen, herbal supplements, etc.)

	NAME	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
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11.			
12.			
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18.			