Authorization to Pay Benefits to Health Care Provider and Release of Information

I hereby authorize the release and use of any and all medical records maintained by, secured by or received from The Shot Nurse – Memphis, P.C., as well as any other of my protected health information, necessary to secure payment for services and products rendered by The Shot Nurse - Memphis, P.C. from any source including insurance claims, third-party payors and/or insurers (whether governmental or private) and for any other purposes necessary to secure payment for the services rendered. I understand I may revoke this authorization in writing at any time but if I do so, it will not have any effect on any actions taken by the releasing of this information prior to receiving a notification. I understand that to the extent protected health information is released pursuant to this release, that the released information may no longer be protected by federal privacy laws and/or regulations and may be re-disclosed. I hereby release The Shot Nurse – Memphis, P.C. and any of all of its employees, agents, servants, officers or directors from any liability and/or claims whatsoever for complying with this authorization and the provision of protected health information to third-parties. The Shot Nurse will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization will not expire unless and until revoked in writing by the patient. I understand that authorizing the disclosure of protected health information is voluntary and I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment or services. However, if this authorization is for release of records to a third-party for payment, enrollment, or eligibility of benefits purposes, such as private insurance, governmental health insurance, etc. **my refusal to sign may affect payment, enrollment, or eligibility for the benefits**. **This, in turn, may affect payment for services I receive, and I may/will become responsible for all charges incurred.**

I authorize payment to The Shot Nurse-Memphis PC (TSN) for services rendered to me. I understand that I am responsible for any balance not covered by insurance and/or collection service costs and legal fees incurred in an attempt to collect said balance.

Authorization to Leave Message I authorize TSN and/or representatives, including a contracted collection agency to leave a message about my vaccination(s), the need for recommended vaccines, or outstanding balances on my home telephone answering machine, or cell phone number provided in my Shot Nurse electronic record.

Receipt of Notice of Privacy I have been offered a copy of the Notice of Privacy Practices as requested by HIPAA Privacy Regulations developed January 2003 and revised June 2009.

Acknowledgement of Financial Responsibility Estimation of benefits should NOT be interpreted as a guarantee of payment. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions and the member's eligibility at the time service(s) are rendered

I have been informed that my health care benefits insurer or administrator may determine that vaccination(s) administered may be an Investigational Service, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member heath care benefits plan. Therefore, the service would be excluded from coverage by my health care benefits plan. I understand that my provider may request that my insurance carrier reconsider that determination by presenting evidence that the referenced service(s) is not an Investigational Service, is a Covered Service or the service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my health care benefits plan, either before or after receiving the services(s). I have been informed that the potential costs if deemed not covered by insurance is as follows for **Shingrix $250.00**. **Flu vaccination 35.00**, **Tdap 70.00, Prevnar 250.00, Pneumovax 130.00, Meningococcal 210.00, administration fee $25. I understand that, if I elect to receive the service(s) and my insurance carrier determines that the service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible for all costs associated with the service(s), including, but not limited to, practitioner/facility cost, ancillary charges and any other related expenses to collection services. I acknowledge that my insurance carrier may not pay for the service(s).**

By Signing I have read and agree to the above: Authorization to pay benefits to Health Care Provider and Release of Information (EOB will show Joseph Holley, MD), Authorization of Financial Responsibility, Authorization to Leave Message, and receipt of Notice of Privacy.

Signature of Responsible Party/Parent/Guardian_____ **Date**_____

Address_____**City**_____

State_____**Zip**_____**Cell#**_____**Email**_____**DOB**_____

Please complete the following for anyone receiving services that is **under the age of 18:**

Name:_____ **DOB:**_____

Name:_____ **DOB:**_____

Name:_____ **DOB:**_____