Vitae Family Care Clinic, LLC
1355 50th St., Suite 100
West Des Moines, IA 50266-1617
Phone (515) 225.3261 | Fax (515) 225.1944

Patient Consent Form

COMMUNITY EXCHANGE
I, the undersigned, hereby authorize Vitae Family Care Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care. I understand and acknowledge that Vitae Family Care Clinic will use and disclose my information for purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

MEDICATION HISTORY
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** — Gives 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.

I, the undersigned, agree that Vitae Family Care Clinic can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

I UNDERSTAND THAT IF I AM ON MEDICATION PRESCRIBED BY VITAE FAMILY CARE CLINIC, I WILL NEED TO BE SEEN ONCE YEARLY IN ORDER TO RECEIVE REFILLS. _______________ (Initial please)

PATIENT REFERRAL (CONSENT TO TREAT)
I, the undersigned, hereby consent to the administration and performance of all treatments, necessary and advised procedures, use of prescribed medication, performance of diagnostic procedures, tests, cultures, or any other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of both myself and the attending physician (or their assigned designees) as agreed upon or as applicable. I fully understand that this may be given in advance of any specific diagnosis or treatment and intent for this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I always have the right to refuse if I have the capacity.

****VITAE FAMILY CARE CLINIC MISSION & POLICIES**
I, the undersigned, understand that Dr. McKernan is a NaPro Technology Medical Consultant and will not administer or refer for birth control pills/devices, in-vitro fertilization, sterilization, abortion, or any other services/procedures, (and even regarding the HPV vaccine, administration will be on a case-by-case basis) , The above are in contradiction with its mission statement because of the commitment to providing higher standards of patient care and medicine free from dangerous side effects and environmental degradation.

PAYMENT & INSURANCE
I, the undersigned, hereby accept financial responsibility for myself and/or my family members. I understand that Vitae Family Care Clinic files insurance as a courtesy to its patients, and I accept responsibility to notify the clinic of any changes in my coverage. I understand that insurance may not cover all services provided, and I agree to pay my copay at the time of service, any deductible amount estimated, and any remaining balance immediately upon receipt of billing statement.

A photocopy of these consents shall be considered as valid as the original. The consents will remain in full force until revoked in writing.

Patient Name: ___________________________ Patient/Guardian Signature: ____________________________Date: _________