CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

BUFORD CARE INC

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Name:

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression

☐ I accept Patient Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

BUFORD CARE INC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Buford Care Inc. (the Practice) to use and disclose my protected health information(PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Patient Name:

☐ I accept -

Patient Signature: _____ Date: _____

BUFORD CARE INC

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human

Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S mail, text message or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I have read and understand this document.

Patient Name:

☐ I accept

Patient Signature: _____ Date: _____

BUFORD CARE OFFICE POLICY

The following policies are in effect for all patients. Please read this carefully and sign at the bottom. If you have any questions, please ask the office staff to clarify. Thank you for your cooperation and understanding.

The providers at Buford Care DO NOT provide chronic pain management nor prescribe Schedule II/III and IV medications for managing chronic conditions except in certain and specific conditions as deemed necessary by the provider.

Medication refills, which are not limited to narcotics, periodically require a visit with a provider before prescription refills can be sent to a patient's pharmacy.

Physician visits are on an appointment basis. It is the policy of Buford Care that patients arriving at the office without a scheduled appointment will be seen only if there is an appointment slot available and may involve a long wait. However, we do reserve an allotted time for same day appointments in the event that you need to be seen the same day you call. Please call ahead to reserve these appointments. All patients with scheduled appointments will be seen before walk-ins, so we encourage you to always call ahead to schedule an appointment. Patients with medical emergencies should go to the emergency room.

Please be aware that the staff at Buford Care does not do venipunctures. All venipunctures will be referred to a local lab facility if a lab test is ordered by a provider.

THE CLINICS OF BUFORD CARE INC. HAVE A STRICT 'NO SHOW' POLICY.
PATIENTS WHO FAIL TO CANCEL SCHEDULED APPOINTMENTS TWENTY-FOUR HOURS BEFORE THE APPOINTMENT TIME WILL BE CHARGED A $35 'NO-SHOW' FEE.

Patients are expected to pay as services are rendered by either cash or credit card in advance. Please note that Buford Care reserves the right to collect payments for services, that fall under a patient's deductible, upfront before the patient's visit. Checks will not be accepted.

The exception to this rule is if the patient has Medicare, Medicaid, Workman's Comp., or insurance that has been agreed to be filed by Buford Care Inc.

By signing this form, the patient gives consent to the clinic to send health and claims information to the patient's insurance, and authorizes insurance payments to be done directly to the clinic.

All outstanding balances, that remain unpaid one-hundred twenty days after the posting of charges, will be sent directly to collections unless the patient notifies the clinic to design a payment plan.

It is the patient's responsibility to be informed on the services that are covered by his/her or their insurance plan. The clinics of Buford Care Inc. do not guarantee that services rendered will be covered by the insurance plan.

In case of declined coverage for any services performed, scheduled, ordered or referred in or outside of our clinics such as laboratory testing, imaging studies, medical specialist and etc., the patient is entirely responsible to manage and clear the matter. Our clinics and our staff members will not act on the patient's behalf to manage similar situations.

It is also the patient's sole responsibility to identify if an authorization from the insurance company is required for any services performed at any of the clinics of Buford Care Inc.

All patients must understand that not every insurance will cover the same services at our clinics. As such, any service that is labeled as the patient's balance (i.e. deductible or coinsurance) is the patient's responsibility to pay.

The Clinics of Buford Care do not provide for any translation. It is the patients' sole responsibility to arrange for a translator if contacting the office in person via phone or any other communication methods.

Buford Care utilizes phone, email, text messaging capabilities to contact patients regarding any issues. The clinics utilize messaging services (i.e patient portal, text message, email) that have end to end encryption to ensure protected health information is kept secure.

By signing this form, the patient consents to being informed through phone, text, email, or patient portal.

It is also the patient's responsibility to update his/her or their contact and demographic information such as a phone number, email address, mailing address, and emergency contact information.

The clinics are not responsible for health or billing information being sent to the wrong phone number, email, or mailing address if patients do not inform the clinic of a change in any one of them.

Protected health information that is required by the patient to be sent to a third party (i.e law office, employer) are allowed as long as the patient signs a consent form to release protected health information giving the clinic permission to do so.

Forms that are required to be completed by office staff or healthcare providers incur a charge between $25–$175.

Our clinics' staffs and providers are striving to perform a high quality care to our patients and that would be only possible if they would be treated with respect and dignity.

We have a zero tolerance for misbehaving and misconduct. Patient's not complying with this regulation will be discharged from our clinics without any warning.

Due to the current COVID-19 pandemic, we will be limiting the number of individuals who can be present in the room with the patient and the provider to adhere to social distancing guidelines for the safety of staff members and providers.

If friends or family members, who have patient consent to be present while the patient is with the provider, wish to be present in the room, we will use virtual options that will allow other individuals to be present in the room with the physician and patient such as Facetime or Google Duo.

By signing the accompanying form, you are stating that you agree with these policies and will adhere to them to the best of your ability.

☐ I accept - ☐ I decline

Patient Signature: _____ Date: _____

BUFORD CARE INC

Consent to Treatment

I hereby give my permission for Buford Care Inc. to give me medical treatment.
I allow Buford Care Inc. to file for insurance benefits to pay for the care I receive.
I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I give Buford Care Inc. the right to perform diagnostic tests, procedures, venipunctures, etc, unless I refuse
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

☐ I accept ☐ I decline

Patient Signature: _____ Date: _____

MOHSEN KHODAKARAM reviewed the above information with the patient _____ Date _09/25/2025_