WINCHESTER OB-GYN ASSOCIATES, P.C.

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CONSENT FOR E-PRESCRIBING AND MEDICATION HISTORY

I understand that as part of my electronic health record, Winchester OB/GYN Associates, P.C., through its associated practitioners, will transmit my prescriptions electronically to the pharmacy I designated as my primary pharmacy provider. As part of this electronic communication, I also consent Winchester OB/GYN Asscociates, P.C., to obtain the history of all my past prescriptions from such pharmacies or pharmacy benefit managers. I understand that this prescription history will become a permanent part of my electronic health record. This consent is necessary for the practitioners of Winchester OB/GYN Associates, P.C., to provide you with optimal treatment and care. The practice reserves the right to refuse to provide medical services to patients who do not consent to electronic prescribing and release of their prescription history.

Signature of Patient or Legal Guardian _____ Date _____

RECORDS RELEASE AND ASSIGNMENT OF INSURANCE

I accept full responsibility for the payment of services rendered to me and agree to pay them in full, at the time of service, unless other arrangements have been made in advance.

I understand that co-payments are due at the time of service and that a $40 fee will be charged for any returned checks.

I authorize payment of insurance benefits directly to Winchester OB/GYN Associates, P.C., for services rendered.

I understand I am financially responsible for any treatment or balances not covered by my insurance company.

Signature of Patient or Legal Guardian _____ Date _____