Consent to Treat/Authorization to Release Information to Insurance Providers for Payers

I am consenting to treatment through the Accident Injury Management provider network. I hereby authorize Accident Injury Management, or its agents to furnish information to insurance carriers, or other third party payers concerning my illness, and treatment. I hereby assign to the physicians all payments for medical services to myself or to my dependents.

I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within thirty (30) days from the date billed, unless I made previous arrangements with ***AIM***. I further agree to pay all collection costs including but not limited to court costs and reasonable attorney's fees, if it becomes necessary to turn this account over to an outside party for collection.

This authorization and release is in effect until I choose to revoke it.

Patient/Responsible Party	Date

Patient Financial Agreement *(continued)*

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

Responsibility for Accident

If you were involved in an auto accident in your own vehicle, and you were the responsible party, we will bill your Med Pay portion of your car insurance policy (if available) for services rendered in our office.

If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services.

If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill your car insurance Med Pay portion (if available) for medical services rendered and require you to sign a lien consent. If your car insurance policy does not include a Med Pay portion, we will also require that you sign a lien consent. By signing the lien consent we agree, as a courtesy to you, to defer payment to your medical bills until your settlement is received. If care is discontinued before your treatment plan is complete, payment of your account will be expected upon settlement to include treatment received for and relating to the motor vehicle accident/injuries in which you were involved.

Responsibility for Payment

As a courtesy to you, we will provide your insurance company and attorney with all the information they might need to negotiate and provide payment for any charges you incur in our office. However, all charges or services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

We hope this has answered any questions you might have about our financial agreements. If at any time you have further questions regarding your financial agreement, please do not hesitate to ask.

I have read, understand and agree with the above financial agreement.

________________________________ ____________
Patient's Signature or Parent/Guardian of minor Date

____
Patient's Name

________________________________ ____________
Witness Date

PATIENT FINANCIAL AGREEMENT *(continued)*

Name **DOB** **SSN**

Third Party Insurance Information

Insurance Company & Claim #

Adjusters Name

Adjusters Phone

Adjusters Fax

Claims Address

Your Automobile Insurance Information

Insurance Company & Medpay or UM Claim #

Adjusters Name

Adjusters Phone

Adjusters Fax

Claims Address

I, ______________________________,
agree to have the aforementioned involved insurance company pay *AIM* directly upon a settlement being made, for any/all treatment costs that are outstanding, incurred due to a motor vehicle accident/injuries on the date: ____________

If stated arrangement cannot be met,
I, ______________________________,
agree to pay *AIM* for all treatment costs incurred with regards to the treatment received for and relating to the motor vehicle accident/injuries in which I was involved on the date: ________

I, ______________________________,
also understand/agree that if no settlement is reached with an insurance company, I am ultimately responsible for all outstanding medical bills relating to the treatment I receive from an *AIM* preferred provider's office. In the event that a settlement is not met, I agree to pay above stated doctor/office for all outstanding medical bills.

I agree to pay said doctor within 10 days of a settlement being made.

Signature of Patient/Guardian: ____________ Date: ________

Signature of Witness: ____________ Date: ________

Consent to the Use and Disclosure of Health Information for Healthcare Operations *(Continued)*

I understand that as part of my health and medical care, **Accident Injury Management** originates and maintains medical and health records describing my health, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying diagnosis and treatment information to my bill.
- A means for a third party payer to verify that services were billed as actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to all information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Accident Injury Management reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand I have the right to request restrictions and that Accident Injury Management is not required to agree to the restriction requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

Consent to the Use and Disclosure of Health Information for Healthcare Operations *(Continued)*

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

I request the following restrictions to the use of my healthcare information:

Patient Signature

Date

Notice of Privacy Practices

Effective date: March 16, 2016

View authroization for Release of Medical Information

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to Accident Injury Management.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access this information.

Please review it carefully.

WHEN IT COMES TO YOUR HEALTH INFORMATION, YOU HAVE CERTAIN RIGHTS. THIS SECTION EXPLAINS YOUR RIGHTS AND SOME OF OUR RESPONSIBILITIES TO HELP YOU.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

NOTICE OF PRIVACY PRACTICES *(Continued)*

- If we deny your request, we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested). We'll provide one accounting a year for free but will charge a reasonable fee if you ask for another one within 12 months.
- You can ask for a paper copy of this privacy notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- ***If you feel we have violated your rights, please let us know by contacting us using the information on the back page of this brochure***.
- You can file a complaint with the ***U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/. • We will not retaliate against you for filing a complaint***.
- *For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions*.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, friends, or others involved in payment for your care
- Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

NOTICE OF PRIVACY PRACTICES *(Continued)*

We typically use or share your health information in the following ways.

- We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
- We can share your health information with your attorney.
- We can use and disclose your information to run our organization and contact you when necessary.
- We can use your information for billing and payment operations.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We are allowed or required to share your information in other ways for the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- We can use or share health information about you: • For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Contact Us

Privacy officer: **Sherry Nofziger**
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