Arrowood Medical Center | Riverview Medical Center | Occumed At Riverview

PATIENT AUTHORIZATION

Private

CONSENT FOR EVALUATION AND TREATMENT

I hereby authorize Arrowood/Occumed/Riverview (which for purposes of this authorization includes its affiliates, physicians, employees, and designate agents, hospitals or laboratories) to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. These may include, but not be limited to, any required medical examination, x-rays, past Rx history, medical procedures and medical, diagnostic or laboratory tests ordered by the center physician(s) to be carried out by the designated center staff. I understand certain special medical evaluations performed by Arrowood/Occumed/Riverview such as pre-placement, annual, or executive physical exams, school/sports physical exams, and other similar services are not intended to replace the medical care of my personal physician and are not intended for purposes of medical diagnosis and/or treatment. **Initials:** _____

CONSENT FOR NON-DOT SUBSTANCE ABUSE TESTING (Not applicable to DOT Testing Programs) If applicable, I voluntarily authorize Arrowood/Occumed/Riverview to obtain a specimen of my urine, blood, saliva, and/or breath for purposes of determining the presence of drugs and/or alcohol and subsequent release of the results as authorized by this document. **Initials:** _____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT (Not applicable to Workers' Compensation)

I hereby authorize and assign to Arrowood/Occumed/Riverview any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to Arrowood/Occumed/Riverview in accordance with the standard and customary charges incurred during my period of treatment. I understand I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within thirty (30) days from the date Arrowood/Occumed/Riverview becomes aware of my insurance ineligibility. Should the account be referred for collection, I understand I shall pay the collection expenses incurred by Arrowood/Occumed/Riverview including, without limitation to, court costs and attorney's fees. I understand and agree to pay a $50 no-show/cancellation under 48 hours fee for missed primary care appointments.

RELEASE OF INFORMATION / NOTICE OF PRIVACY PRACTICES

I hereby authorize Arrowood/Occumed/Riverview to disclose to my insurance company or any third party payer (and/or my employer/ prospective employer if found to be work-related) all medical information, test results and findings made during the course of this examination and/or treatment. I authorize the center to release any appropriate information concerning my medical history, examinations, treatments, or other diagnostic procedures, including copies of my records to official requesters. These include but are not limited to insurance companies, third party administrators, or utilization review organizations, healthcare service plans, or to any other person or entity as necessary in connection with certification, payment or reimbursement for services rendered. I acknowledge the medical information above may be released pursuant to the following paragraphs:

- It is the policy of Arrowood/Occumed/Riverview to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand medical records may be periodically reviewed by national accreditation or certification surveyors, on-site clinical pharmacy and other necessary quality assurance personnel and I authorize such release of information for these purposes only. I acknowledge my records and associated documentation may be disclosed to third-parties, including government agencies, as required by law, including, but not limited to, pursuant to a warrant, subpoena or court order, and I hereby agree not to pursue any action against Arrowood/ Occumed/Riverview for any damages I may suffer as a result of such disclosure.
- I acknowledge I have reviewed (either today or previously) the HIPAA Notice Of Privacy Practices.
- I elect to allow ❒ **No one** *or* ❒ **the following** to receive information regarding my medical treatment and care including (as indicated in box below):
  1. Appointment information, date, time and scheduling of visits
  2. Medical information discussed with my physician and/or copies of my medical records
  3. Test results, written or verbal
  4. Payment and billing information

Authorized Person	Relationship	Date of Birth	Information to be released (Check 1, 2, 3 and/or 4)
			❒ 1 ❒ 2 ❒ 3 ❒ 4
			❒ 1 ❒ 2 ❒ 3 ❒ 4
			❒ 1 ❒ 2 ❒ 3 ❒ 4

- In the case of contact from the clinics for follow-up information (test results, prescriptions, insurance info, etc.)...

My daytime phone # is ( ) _____ and you ❒ may or ❒ may not leave a message regarding my care.
My evening telephone # is ( ) _____ and you ❒ may or ❒ may not leave a message regarding my care.
You ❒ may or ❒ may not text me an appointment reminder at my cell phone # ( ) _____.

- This consent/authorization shall be in force and effect for **one year.** I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand if I choose to revoke my consent I must submit a written statement that it is signed by me and notarized. By signing this authorization form I acknowledge I have fully read or had this form read and/or explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and questions have been answered satisfactorily.

Patient Name: _____ Date: _____

Patient/Legal Representative Signature: _____ Relationship: _____