CONSENT AND PAYMENT AUTHORIZATION FORM

SOURCE: HIPAA

LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA CONSENT AND PAYMENT AUTHORIZATION FORM

I. Consent and Authorization for Release of Information

1. **Release of Information:** I consent to the release by LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA of health records and other information about me to the extent permitted by law to the following persons and organizations:
   - To a health care provider being advised or consulted in connection with my treatment or care, including to those health care providers who share electronic health record systems with LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA;
   - To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews;
   - To a person or organization in connection with LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's health care operations. These operations may include but are not limited to interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities;
   - To any person or organization retained by LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA to assist with the payment or collection of amounts owed for health services provided by LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA;
   - To a person or organization providing services in connection with LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's patient health record portal or the person or organization hosting or providing the portal service;
   - To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations;
   - To a record locator service or patient information service, **unless** I check this opt out box: ☐
     "Record locator services" and "patient information services" help enable health information exchange among unrelated health care providers. These services are used by health care providers to electronically search for and locate the health records of their patients that are held by other health care providers.

2. **Record Locator/Patient Information Services:** I consent to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA searching for, accessing, and/or receiving health information about me and the location of my health records through a record locator service and/or patient information service.

3. **Revocation:** I understand this consent is valid until I revoke it, which I may do at any time by giving written notice to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA.

II. Payment Authorization

1. **Payment Responsibility and Collection:** I agree to pay for all services furnished to me by LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA and any providers performing services on my behalf at the request of LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's contract with my health plan or applicable law. I also agree to pay or reimburse LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA for all costs it may incur in collecting such amounts. Further, if I fail to pay on time and my account is referred to a third party for collection, I understand and agree that a collection fee may be assessed and be due at the time of the referral to the third party. Any such fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent per year.

2. **Payment Authorization:** I authorize LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA to directly bill my health plan or third-party payor for services rendered to me by or on behalf of LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA, but acknowledge that LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a third-party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA directly on my behalf by my Medigap insurer. I understand and agree that LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf. As further discussed above, I understand I am financially responsible to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA for charges not covered by insurance.

3. **Statement to Permit Payment for Medicare Benefits to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA:** If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA, for any services furnished to me by or in LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. **Confidentiality.** It is the policy of LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA to protect the privacy and confidentiality of patients' medical information.

2. **Notice of Privacy Practice.** LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's Notice of Privacy Practices explains how LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA may use and disclose my medical information. It also explains my rights regarding this kind of information. LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's Notice of Privacy Practices is available at any and all patient access areas of Lakewood Health System.

   Lakewood Health System is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Lakewood Health System, OCHIN supplies information technology and related services to Lakewood Health System and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Lakewood Health System with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operations can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

   The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent; however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed."

3. **Acknowledgment of Receipt:** I acknowledge I have received LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's Notice of Privacy Practices.

4. **Video Surveillance:** I acknowledge video surveillance equipment is on premise for patient safety purposes. Patient confidentiality is respected per LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA's video surveillance policy.

IV. Patient Bill of Rights

A copy of the Minnesota Patient Bill of Rights has been made available to me.

V. Consent for Treatment

I understand I have the right to be informed of the nature and purpose of all services provided to me at Lakewood Health System/Lakewood Clinic PA, as well as alternatives, risks, consequences, or complications of such services. I hereby authorize and consent to the examination, diagnosis, procedures, and treatments which my practitioner and I agree are necessary. I understand no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

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VI. Consent to Receive Automated, Prerecorded and Electronic Communications

I understand that LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA and its business associates and affiliates sometimes use automated, artificial voice and/or prerecorded messages, voicemails, text messages, and electronic mail to communicate with patients about their health care and related matters. These communications may include, but are not limited to, the following: appointment confirmations, wellness check-up and follow-up care reminders, pre-appointment instructions, prescription-related notifications, patient satisfaction surveys, billing notifications, communications relating to the collection of unpaid medical debts, and other financial-related notifications.

By signing below, I consent to receive automated, artificial voice and/or prerecorded messages, voicemails, text messages, and electronic mail about my health care and related matters, including but not limited to those communications specifically described above, from LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA and its business associates and affiliates. I agree that these communications may be sent to the home telephone number, cellular telephone number and/or email address that I provide below or any home or cellular number or email address that I may provide to LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA in the future.

I understand that I may opt-out of receiving the above-described communications by checking the box below or, at any time in the future, contacting LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA:

☐ I do **not** consent to receive the above-described automated, prerecorded and electronic communications about my health care and related matters from LAKEWOOD HEALTH SYSTEM/LAKEWOOD CLINIC PA and its business associates and affiliates.

VII. Consent to the potential use of DAX during your Clinical Encounter

DAX is an ambient, voice-enabled technology that securely captures and processes conversations between the patient and healthcare provider during a clinical encounter. It then generates a draft clinical note, which is reviewed, edited (if necessary), and approved by the provider. The approved clinical note is included in the patient's medical record.

Audio Recording Only: DAX captures audio only; no video or images are recorded.

Limited Use: The audio recording is used solely for the purpose of creating accurate clinical notes.

Privacy and Security: DAX operates in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws. Audio data is encrypted and processed through secure, HIPAA-compliant systems.

Data Access: The approved clinical note becomes part of the patient's medical record. The audio recording is securely destroyed within 365 days after the clinical note is made part of the patient's medical record.

Right to Decline: Participation in DAX is voluntary. A patient or a patient's representative may decline the use of this technology at any time, either prior to or during the visit, without affecting the patient's access to care or services.

By signing below, you: (1) acknowledge that you have read and understand the above information, (2) agree that all your questions about DAX have been answered to your satisfaction, and (3) voluntarily consent to the use of DAX during your clinical encounter(s) with your Lakewood Health System healthcare provider.

Patient's name _____ Date of birth _____

Name of patient's legal guardian (if applicable) _____ Relationship _____

Home phone _____ Okay to leave voicemail? Yes _____ No _____

Cell phone _____ Okay to leave voicemail? Yes _____ No _____

Email address: _____

Signature of patient or patient's legal guardian _____

Date _____

This institution is an equal opportunity provider and employer.