St. Paul Allergy & Asthma

Diplomates Of The American Board of Allergy & Immunology

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PATIENT CONSENT AND RELEASE FORM

To Our Patients and Families: This document explains your rights and responsibilities as a patient of St. Paul Allergy & Asthma (SPAA). By signing this form, you give your consent for treatment, payment, and sharing of medical information (protected health information - PHI). Your signature also acknowledges you have received and understand this information. If you have any questions, please contact SPAA's Privacy Officer or Clinic Administrator though your preferred form of communication using the contact information at the top of the page.

Consent for Treatment: I authorize the physicians, nurses, and other healthcare providers at SPAA to examine and treat me as they deem medically necessary using their professional judgment. I am consenting to lab work, diagnostic testing, allergy testing, and medication administration. I know that there are some risks with all medical treatments and procedures, and I understand that no one can promise exact results. My provider will explain the purpose of the testing, procedure, and treatment. I have the right to refuse part or all the treatment or testing.

Patient's Rights to Privacy: The Health Insurance Portability and Accountability Act (HIPAA) gives you certain rights regarding the use and disclosure of your medical information (PHI). You and your family's rights are available in SPAA's main reception area and the information is also available on our website at www.stpaulallergy.com. If you would like a copy of our HIPAA privacy notice, please ask for one. Your signature acknowledges that you have been notified of this policy and understand its meaning.

Medical Records Release: I consent to and authorize SPAA to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operations – including: prior authorizations, care coordination, and quality assessment and improvement activities

Release for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and the other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purpose stated above to SPAA or a clinically integrated network or accountable care organization in which SPAA participates.

Electronic Health Information Exchange (HIE): I agree to and understand that my SPAA healthcare providers may get or share my health information from an HIE or similar database service. A health record locator service may be used to tell SPAA where I've had care and what medications I have been prescribed. If I do not wish SPAA to get or share my health information I will check this box. ☐

Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to St. Paul Allergy & Asthma for any services furnished to me by that physician/clinic/supplier. I authorize the holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those and all other charges for services rendered.

_____ _____

Signature Date

Payments for Services and Release of Information for Billing and Payment: I know that I must pay for any charges for my care that are not covered by my insurance company, health plan, or government programs. To get payment from my insurance company, health plan, or government agencies, SPAA must give them information from my medical records. I understand that I must cooperate with SPAA to get payment for my care.

I hereby authorize SPAA to release requested medical information (PHI) to my insurance company in order to collect payment for my medical bill. I also request and authorize my insurance company to pay SPAA directly for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to me and/or for charges for services not covered by my insurance policy for myself and my dependents.

I understand that a monthly service charge of 1 $^1/_3$% per month will be applied to all account balances sixty days old or older.

Communication: (Please complete all phone numbers and check the box of your preferred phone contact)

Phone: ☐ *Home #:* _____ ☐ *Mobile #:* _____ ☐ *Work #:* _____

Email Address:

I give SPAA permission to contact me or leave scheduling, medical (PHI), and billing information on the following forms of communication (circle all that apply): ***Home*** ***Work*** ***Cell*** ***Text*** ***Email***

Consent to Discuss Medical Treatment:

I hereby authorize SPAA to discuss my diagnosis, care, treatment and plan with:

_____	_____	_____
First and Last Name	Relationship to Patient	Phone Number
_____	_____	_____
First and Last Name	Relationship to Patient	Phone Number

If I have concerns with this consent, I will discuss them with the staff member who is helping me with this form. I am signing that I have read this information and that I understand it. This signature is valid for two (2) years from the date of the signature. I may revoke any or all of this consent at any time by completing a new authorization or writing a letter revoking it. I also understand that any actions taken while my consent was in effect **can not** be undone.

_____ _____

Printed Name Date

_____ _____

Signature Relationship to Patient