



Master Acknowledgment | Consent Form

Patient Name: _____ Date of Birth: _____

Parent or Legal Guardian: _____

I as the patient, parent, or legal guardian consent or agree to the following *(initial next to all that apply)*:

- Assignment of Benefits:** I assign to and authorize payment of all insurance, and health care benefits available to the subscriber directly to IHA for services provided to the patient. I understand that benefits may be payable to the subscriber directly if I do not provide this authorization.
- Authorization to Share:** I have been given an opportunity to authorize another individual to be involved in my care.
- Consent to Treat a Minor (In Parent's Stead):** I have been offered an opportunity to have a third person representative to act on my behalf regarding the treatment of my minor child (in my stead).
- Consent to Treat:** The patient above is being treated at IHA, and I consent to all medical care, examinations and tests determined by the Physician to be necessary for the patient. I understand I have the right to decline services and testing, and I assume full responsibility and release IHA and the Physician relating to services and testing for which I decline. I do however, understand that financial assistance is available if I should need it. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.
- Consent to Use of Information:** I understand that IHA may collaborate with other healthcare providers to coordinate, manage and provide health care to the patient. I consent to IHA sharing my health information and records electronically for the purpose of treatment, payment or health care operations including eligibility verification, insurance payers, state and federal programs, Workers' Compensation, quality improvement, compliance and health care oversight activities, POM ACO and Health Information Exchanges. This collaboration improves the overall quality care services to the patient. I understand that the electronic health record (EHR) includes sensitive diagnoses and related information such as HIV/AIDS, Sexually Transmitted Diseases, Genetic Information, Behavior Health and Substance Abuse, and Pregnancy and Prenatal Care. The electronic health record will be accessible by IHA/Trinity Health credentialed physicians and providers; Clinsite and Cancerling (research partners), Health Information Exchanges, Insurance or Government Innovative Care Models; other individuals approved to access the EHR for purposes related to treatment, payment and health care operations and/or other purposes permitted by HIPAA. As required by HIPAA, IHA has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and security of the Protected Health Information (PHI).
- Missed Appointment Policy:** I Acknowledge receipt of IHA's Missed Appointment Policy and agree to notify the office as soon as possible if unable to keep the scheduled appointment time.
- Notice of Privacy Practices:** I AGREE I have received or been offered a copy of IHA's Notice of Privacy Practices which provides information on how IHA may use or disclose PHI. I have been given an opportunity to opt-out of certain uses or disclosures of the patient's PHI if I choose to by completing an opt-out form.
- Patient Financial Obligation:** I AGREE I have received or been offered a copy of IHA's Patient Financial Obligation Policy. I understand that I am financially responsible for charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to the patient which are not eligible for payment (non-covered, i.e., co-insurance, deductible, copay, etc.).

Patient Signature: _____ Date Signed: _____

Parent or Legal Guardian Signature: _____ Date Signed: _____

NOTICE OF PRIVACY PRACTICES

We are **IHA**, (IHA Health Services Corporation), a group practice with primary care and multi-specialty health care providers serving you at IHA office locations. Who will follow this Notice: Our affiliates, IHA Investment Holdings, LLC, Clinsite, Saint Joseph Mercy Health System (SJM), and Trinity Health, Livonia, Michigan; in addition IHA participates in quality improvement and assessment activities as part of a Physician Organization of Michigan Accountable Care Organization and Insurance or Government Innovative Care Models. IHA shares your health records electronically with your other healthcare Providers in the Health Information Exchange for the purposes of improving the overall quality of health care services provided to you. (e.g., avoids unnecessary duplicate testing). The electronic health records will include sensitive diagnosis such as HIV/AIDS, sexually transmitted diseases, genetic information, mental health substance abuse, pregnancy and prenatal care, etc. Providers and hospital systems in this arrangement work jointly to improve the quality and coordination of your care so that appropriate information is available to your provider to make timely and informed decisions. All of these entities or locations may share health information with each other for treatment, payment, or health care operation purposes described in this notice.

This notice is effective March 1 2018, and describes how information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.

A federal regulation, known as the “HIPAA Privacy Rule,” requires that we provide detailed notice in writing of our privacy practices; we know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us.



IHA
P.O. Box 0446
Ann Arbor, MI 48106-0446

This Notice describes your rights as our patient and our obligations regarding the use and disclosure of health information. Law requires us to:

- Make sure that health information that identifies you is kept private;
- Offer you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Comply with the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

The following categories describe the different ways we may use and disclose health information for treatment, payment or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: We may use and disclose health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor’s office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, testing or treatment. For example, we may use and disclose health information when you need a prescription, lab work, x-ray, or health care services. In addition, we may use and disclose health information about you when referring you to another health care provider, including electronic transmission when necessary to other physicians for treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to, and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We share information with Cancer Linq, a learning intelligence network for quality. We may remove information that identifies you from this set of health information so that others may use it to study health care delivery without learning who our specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you wish us to use a different telephone number or address to contact you for this purpose.

Health-Related Services and Treatment

Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know in writing, if you do not wish us to send you this information, or if you wish us to use a different address to send this information to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. In addition, we may disclose information to Clinsite, a subsidiary of IHA.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another

person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers’ Compensation: We may release health information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities as required or permitted by law. These activities generally include the following: To prevent or control disease, injury or disability; to report births and certain deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify person or organization required to receive information on FDA-regulated products; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fundraising: We would not use or disclose your information for fundraising activities unless we first contacted you and obtained your authorization. You can tell us not to contact you again about fundraising.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court order, or appropriate administrative order as required by law, that is signed by a judge. For other requests, we comply with a valid patient authorization.

Law enforcement and Inmates: We may release health information if asked to do so by a law enforcement official in certain limited cases: In response to a court order, warrant, or similar process signed by a judge; If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors, as necessary to carry out their duties.

National Security, Protective Services for the President and other Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

Right to Inspect and Copy: You have the right to inspect and receive a paper or electronic copy of health information that may be used to make decisions about your care. Usually, this includes health and billing records. To inspect and copy health information please contact the person responsible for record disclosures at your office location. A written request is required. If you request a copy of health information about you, we may charge you a reasonable fee for copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy health information only in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may request that we amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to IHA's Compliance Officer, and must be contained on one page of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete

Right to Receive Confidential Communications: You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you may request that we only contact you at work or by mail to a post office box. You must make your request in writing to IHA's Compliance Officer at the address below. You must specify how you would like us to contact you (for example, by regular mail to your post office box and not your home). We are required to accommodate reasonable requests.

Right to Request Sharing or Restrictions: 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 verify that the person has this authority and can act for you before we take any action. You have the right to request a restriction or limitation on the health information that we use for disclosure about you for treatment, payment and health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we

may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request a restriction, you must make a request in writing to IHA's Compliance Officer at the address below. In your request, you must tell us what information you want to limit and to whom you want the limits to apply, for example, disclosure of specified surgery to your spouse.

Michigan – Health Information Exchange (HIE) – Great Lakes Health Connect (GLHC) Opt Out: HIE electronically moves personal health information securely among doctors, hospitals and other health care providers when it is needed for your care. Your health care provider exchanges electronic medical records through GLHC. GLHC complies with all state and federal regulations regarding the privacy and security of health information. You have the right to opt out and prevent your health information from being sent to the Michigan Health Exchange by completing and submitting an “Opt Out” form. Mail or Fax or Website information is below. Additionally, you may contact GLHC or IHA if you have any questions or concerns.

**Great Lakes Health Connect
695 Kenmoor Ave. SE, Suite B
Grand Rapids, MI 49546
Phone: 844.454.2443
<http://gl-hc.org/>**

Right to Receive an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to IHA's Compliance Officer. Your request must state a time period that may not be longer than six years. The first list that you request in a 12-month period will be free, but for additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time. To obtain a copy of this notice, please speak with the receptionist at your office location. You may also obtain a copy of this notice from our website: www.ihacares.com.

CHANGES TO THIS NOTICE:

We reserve the right to make changes to this Notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact IHA's Compliance Officer at the address and number listed below. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PRIVACY OFFICIAL CONTACT INFORMATION

**IHA Compliance Officer
IHA Health Services Corporation
P O Box 0446
Ann Arbor, MI. 48106-0446
(734) 747-6766 ext. 10453**

Acknowledgement of Receipt of this Notice: We will request that you sign a separate form or notice acknowledging you have received a copy of this Notice. If you choose not to sign, or are unable to sign, a staff member will sign their name, date and confirm the Notice has been offered to you.



Patient Financial Obligations

IHA is dedicated to providing the best possible care and service to our patients in a cost effective manner. We regard the patient's prompt handling of their financial responsibility as essential to ensure that we can provide quality services. In order to accomplish this, we depend upon prompt payment for the services we provide. To reduce any misunderstanding or confusion, we have adopted the following policy.

Payment options if you have insurance: IHA has made prior arrangements with most insurance companies and health plans to accept assignment of benefits. We will file a claim with all insurance companies we participate with. Please be advised that unreported changes in medical insurance could result in billing delays, rejections and personal responsibility for the services provided.

Financial Responsibilities:

- A. You will need to pay your deductible, co-pay and any determined out-of-pocket portions at the time of service.** Unpaid co-pays will be reported to your carrier since this is a requirement of your insurance plan, and may affect your insurance coverage.
- B.** If IHA does not have a contract with your insurance company, you will be given an itemized statement to file with your insurance plan and will be responsible for the charges at the time of service.
- C. Bring your current insurance information to each visit.** Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. **It is your responsibility to understand your insurance benefits to include deductible amounts.**
- D.** In the event that your health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges at the time of service. If we are unable to verify coverage, you will be asked to sign a waiver (written acknowledgement) that these charges may not be covered and you will be responsible for prompt payment of the all uncovered services.
- E.** You should understand that your failure to meet your financial obligations to IHA may include (but is not limited to) additional actions such as written correspondence, collection activities, reporting to outside credit bureaus and termination of your patient relationship with IHA.

Payment options if you have no insurance: Payment is expected on the day that treatment is rendered unless prior arrangements have been made. You can pay by cash, check, MasterCard, VISA or Discover. Alternative payment plans may be available for those patients who qualify (when made prior to your appointment). You may inquire about this with an IHA financial representative at your office.

Patient Appointments: We make every effort to see our patients promptly, likewise we ask that you arrive 15 minutes before your scheduled time to register and complete paperwork so that your arrival time does not impact our ability to keep our scheduled times with you or other patients. Note that patients who are sick or have a serious problem often need to be seen on the same day. The office reserves the right to charge for "missed appointments", and you should be familiar with our missed appointment policy. We ask that patients call the office promptly if you expect to be a late arrival, are unable to keep an appointment, or need to reschedule.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent or legal guardian to be treated. Any exception requires the parent or legal guardian to provide IHA, prior to treatment, a signed "Authorization" to provide medical treatment.

Monthly Statement: If you have a balance on your account you will be billed promptly. It will show separately the patient balance due for each visit. The total amount due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt.

Billing Fees: Any balances not paid upon receipt of your statement will be assessed a monthly **late charge** at the rate of 1.5% of the outstanding adjusted balance of your account. The adjusted balance is determined by taking the patient balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. Collection Fees of \$33 per transaction will be assessed for returned or NSF checks. Further collection activity and late charges can be avoided by the timely payment of your account.

I HAVE READ THE ABOVE PATIENT OBLIGATIONS AND I AGREE TO FOLLOW THIS POLICY. I ALSO UNDERSTAND THAT I SHOULD CONTACT AN IHA FINANCIAL REPRESENTATIVE FOR ASSISTANCE WITH BILLING QUESTIONS AT: 734.997.7700.