RURAL HEALTH GROUP
healthcare that fits your family

Patient Agreement

Consent for Diagnosis and Treatment. I voluntarily consent to receive health care services provided by Rural Health Group (RHG) providers and employees and other health care providers as my health care provider(s) deem **necessary**.

- I understand that such services may include diagnostic procedures, examinations, and treatment.
- I understand photographs, videotapes, digital, and/or other images may be recorded for treatment purposes.
- I acknowledge that no warranty or guarantee has been made to me as to result or cure.
- I understand that this Consent to Treatment will be valid for a 12-month period unless revoked by me in writing with such written notice provided to each clinic attended by me.
- I hereby agree to performance of such treatment that is, in the opinion of the attending provider, deemed necessary.
- I authorize SureScripts to provide RHG with full access to my prescription history contained in the SureScripts national database.

NC Health Information Exchange (NC HIE). A Health Information Exchange (or HIE) is a way of sharing patient health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers. The purpose is to ensure that each caregiver has the most recent information available from other providers. Having timely access to this more complete and accurate health record will help providers work together more easily, make better decisions about patient care, eliminate redundant forms and tests, and reduce mistakes. RHG is now live with NC Health Information Exchange (NC HIE). This means that RHG has started sending patient data to NC HIE's secure health information exchange network. I understand that RHG will send my data to the NC HIE. I understand that if I do not want to participate in the HIE, I must complete an opt-out form and return it to the NC HIE. I understand that if I chose to opt out, my information will still be sent to the HIE, but will not be VISIBLE to other providers.

Consent for Release of Medical Information. Rural Health Group, licensed physicians and other health care professionals involved in providing my care at RHG are authorized to use and release my medical information obtained during visits to RHG, including all its specialties, for purposes of treatment, payment and health care operations as stated in *RHG Notice of Privacy Practices*. I understand that my medical information could include medical history or information regarding first time diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, tuberculosis or hepatitis), mental illness, alcohol or substance abuse. By signing this document I am acknowledging and certifying that I have received a copy of the *RHG Notice of Privacy Practice*.

Patient's Certification, Assignment of Insurance Benefits and Guaranty of Payment. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, for any government benefits or for any insurance benefits is correct. I hereby authorize payment of insurance, government or other third party payer benefits, including major medical, directly to RHG. I also authorize payment of surgical and/or medical benefits, including major medical, directly to all treating and supervisory providers and entities, whether direct or indirect. I understand that I am financially responsible for, agree to pay and guarantee payment in full of any and all charges for services provided to me by a RHG provider involved in providing treatment or consultation to me at RHG, even if such treatment is not covered by insurance. I understand that my bill will be sent to the address on file unless I complete a request for my bill to be sent to an alternate address. I authorize RHG to act as attorney-in-fact (act in my behalf) with regard to:

(1) Collection of benefits from any responsible third party through whatever means necessary; and (2) endorsement of benefit checks made payable to me and/or RHG. If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including reasonable attorneys' fees. I authorize payment of any refund that is due of any overpaid insurance benefits to be paid to the appropriate payer in accordance with my insurance policy conditions or any applicable benefit provisions where my coverage are subject to a coordination of benefits clause. With regard to any refund due to me, I authorize the immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by RHG. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Medicare Accountable Care Organization Beneficiary Notice. RHG is part of a Medicare Accountable Care Organization called Carolina Medical Home Network ACO. This ACO is made up of all RHG providers along with providers from other health centers in North Carolina. The members of the ACO are all working together to provide their Medicare beneficiaries with access to high-quality coordinated care, while helping to slow health care cost growth. If I receive Medicare benefits, CMS has placed me in this ACO. I understand that my personal health information will be gathered by the ACO in order to have a better understanding of my health so that the care and advice I receive at RHG considers my total health picture. I understand that if I do not wish to share my personal health information with the ACO, I do not have to and will need to fill out an opt-out form or call 1-800-Medicare and opt-out over the phone.

I understand that this consent will remain in effect for a 12-month period or until I revoke my consent. I understand that I may request restrictions on disclosure of any of the above health information by completing the *RHG Request for Restriction of Health Information Form*. I also understand that I may revoke or discontinue my consent at any time by notifying RHG in writing, except to the extent actions have already been taken based upon my consent, including the disclosure of information to third party payers to seek payment for the care and treatment provided to me. I understand that information disclosed pursuant to this consent may be subject to re-disclosure and would not be protected under the terms of the federal privacy rule. I understand and agree to the above release, authorizations, acknowledgment and assignments of benefits. By signing this document I am acknowledging and certifying that I have received a copy of the *RHG Notice of Privacy Practices*.

Patient Name (Printed): _____ DOB: _____

Signature (Seal): _____ /_____ Date: _____
(Patient or legal guardian/closest relative/authorized representative, if the patient can't sign it) *Relationship to Patient*

If under 18, print name of Parent/Guardian or Representative: _____

Signature (Seal): _____ /_____ Date: _____
(Parent/Guardian or Representative) *Relationship to Patient*