COMMUNITY PHYSICIAN GROUP | COMMUNITY MEDICAL CENTER

CONSENT FOR DIAGNOSIS AND TREATMENT
HIPAA PRIVACY AUTHORIZATION

Patient Name: _____ **Date of Birth**: _____

HIPAA Privacy Authorization:

I agree that medical information may be left on my answering machine: Yes _____ No _____

I authorize access and disclosure of my Protected Health Information (PHI) be given to the following people:
Name _____ Phone: _____ Relationship: _____

Name _____ Phone: _____ Relationship: _____

Notice of Privacy Practices: I acknowledge that the Notice of Privacy Practices was provided to me during my first visit with Community Physician Group. Another copy will be provided to me at any time upon my request.

Patient Rights/Patient Self Determination Act: I have received a copy of the Patient Rights and Responsibilities for Community Medical Center/Community Physician Group. _____ Initials

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Patient Billing Practices: As a courtesy to our patients, this clinic with file a claim with the primary insurance on your behalf. All charges regardless of the insurance coverage are the patient's responsibility. We ask that you provide us with the current insurance information at the time of service. This office will require a copy of the front and back of the insurance card for claims submission information. If unable to provide this clinic with the insurance information at the time of service, you will be considered self-pay and responsible for the visit at time of service.

This clinic will collect your co-pay amount at the time of service. Please bring your co-pay amount and insurance information to every visit.

Consent for Treatment: I give consent for diagnosis and treatment to Community Physician Group, its medical staff, its contractors and its employees to provide medical services and administer provider orders.

I hereby authorize Community Physician Group to furnish information to insurance carriers regarding my illness and treatment with respect to service rendered. I assign all payment for services rendered to Community Physician Group. I understand that I am financially responsible for all charges.

I have read and understand the contents of this consent for treatment and certify that the foregoing information is true, accurate and complete. I also agree to the terms of this disclosure.

_____ _____

Patient/ Patient Representative Signature Date

1. **General Admission Consent:** The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians. The undersigned consents to and authorizes the administration and performance of diagnostic or therapeutic procedures that are necessary or helpful in carrying out treatment which in the judgement of the attending physicians may be considered necessary and advisable. This paragraph does not preclude the taking of special consents that may be required.

2. **Students:** I recognize that Community Medical Center participates in various medical and paramedical training programs involving students and that students from such programs may participate with qualified personnel in my care.

3. **Release of Information: EMERGENCY DEPT. PHYSICIANS, RADIOLOGISTS, PATHOLOGISTS, AND ANESTHESIOLOGISTS ARE INDEPENDENT PHYSICIANS.** They are not employees of the hospital and will bill separately. Authorization is hereby granted to Community Medical Center, Emergency Dept. Physicians, Radiologists, Pathologists and my Anesthesiologists to make any inquiries to determine my eligibility for third party coverage and to release such medical record information, including but not limited to diagnosis and emergency room information as may be necessary for the completion of my hospital insurance claim(s). There may be circumstances under which information must be mandatorily reported. These circumstances include diseases or lab results that require reporting to organizations such as Health Departments or Center for Disease Control and Prevention. **THIS RELASE ALSO INCLUDES THE RELEASE OF INFORMATION PERTAINING TO ANY PSYCHIATRIC CARE, PSYCHOLOGICAL CARE, OR TREATMENT FOR DRUG OR ALCHOL ABUSE.**

4. **Personal Valuables:** It is understood and agreed that the hospital maintains a safe for safekeeping of money, rings, credit cards and checkbooks only. Hospital shall not be liable for the loss or damage to any articles of value, unless placed in the safe, and shall not be liable for loss or damage to any personal property, unless deposited with the hospital for safekeeping. It is strongly recommended that personal valuables be left at home, or sent home.

5. **Assignment of Insurance:** I hereby assign my rights and authorize and direct my insurance company, or any other liable insurance company or any other concerned party, including but not limited to Medicare, to make payment directly to Community Medical Center, Missoula Radiology, Emergency Dept. Physicians, Pathologists and my Anesthesiologists. This assignment and direct payment authorization shall include any payments for physicians services billed by Community Medical Center in connection with its services. This agreement shall specifically include emergency room physician treatment. **CMC makes no representation as to whether or not the physicians participate in or accept assignment for the patient's specific insurance or payor plan.**

6. **Financial Agreement. I UNDERSTAND, WHETHER SIGNING AS PATIENT OR AGENT, THAT TERMS OF PAYMENT FOR SERVICES RENDERED ARE PAYMENT IN FULL WITHIN 30 DAYS OF SERVICE OR BALANCES REMAINING AFTER INSURANCE PAYMENTS ARE DUE WITHIN 30 DAYS OF THE INSURANCE PAYMENT UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE.** I also understand that I am responsible for all charges incurred regardless of insurance or third party liability, unless verified as eligible for Medicare or Medicaid (excluding applicable co-insurance, deductibles and non-covered charges). I will pay the account in accordance with the regular rates and terms of the hospital for an in consideration of services rendered. I agree that I may be responsible for 100% payment of the account. **Should I not pay this account as due, I will be liable for any court, attorney or collection fees incurred by Community Medical Center in collection of any balance due on the account for services rendered. All inpatient accounts bear interest on the unpaid patient balance as of the last day of each month and at the rate of 0.8% per month (annual percentage rate 9.6%).**
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

7. **Medicare (TRICARE/Champus) Beneficiaries:** I have or will receive "An Important Message from Medicare" or (TRICARE/Champus)." The answers I have given to the Medicare secondary payor questions are accurate to the best of my knowledge.

8. **Patient Rights/Patient Self Determination Act:** I have received a copy of the PATIENT RIGHTS and Advance Directive information. _____

9. I consent to members of the Community Medical Center team to have access to my medical records, which may be used for continuity of care _____.

10. **Notice of Information/Privacy Practices:** I acknowledge that the Notice of Information/Privacy Practices was provided to me during my first visit to Community Medical Center on or after April 14, 2003. Another copy will be provided to me at any time upon my request.

11. If you have any concerns about patient care and safety, **please contact Community Medical Center. If Community Medical Center is unable to satisfy any concern about patient care and safety, Joint Commission may be contacted at 1-800-999-6610 or complaint@jointcommission.org and/or The Facility Licensing Division of the MT Department of Public Health and Human Services at 1-800-762-4618 or 2401 Colonial Dr., Second Floor, Helena, MT 59620.**

12. In the event a healthcare worker is exposed to my blood or body fluid in a manner posing a risk for transmission of a blood borne infection, I give my consent to be tested for infections such as HIV, Hepatitis B and Hepatitis C at no cost to me so the healthcare worker may be treated promptly. I understand that testing for such infections following an exposure is planned and will be routinely performed.

The undersigned certifies that he/she has read the foregoing, has received a copy thereof, and is the patient or is duly authorized by the patient to execute the above and accept its terms.

Signature: _____ **DATE OF SIGNING** _____ **TIME** _____

INITIAL DISCLOSURE STATEMENT
DISCLOSURES REQUIRED BY FEDERAL LAW

Your account is subject to the following terms and conditions:

1. A FINANCE CHARGE will not be imposed against the principle balance of the patient's account during the first 60 days following the date(s) of service. A FINANCE CHARGE may be imposed on a thirty day cycle thereafter. The date of the first FINANCE CHARGE is day one in the thirty day cycle. If the amount under "Total New Balance" on the periodic statement is received on or before the next FINANCE CHARGE cycle, the patient will incur no additional FINANCE CHARGE. If a payment is received on or before the date when the next FINANCE CHARGE is imposed, the patient will incur no additional FINANCE CHARGE for that cycle.

2. The amount on which a FINANCE CHARGE may be imposed is the unpaid principal balance of the account.

3. The amount of the FINANCE CHARGE is determined by multiplying the unpaid principal balance by a periodic rate of 0.8% per month. The corresponding ANNUAL PERCENTAGE RATE IS 9.6%.

4. Each payment shall first be credited to the then accrued FINANCE CHARGE and the balance shall then be credited to the unpaid principal balance of the account.

5. Except for any security interest which hospital may possibly acquire by virtue of Montana's Hospital Lien Law §§71-3-1111, M.C.A. 1981, hospital is not claiming any security interest in any of the patient's property.

6. The following statement contains important information regarding your rights to dispute billing errors.

IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1. If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:

   (a) Do not write on the bill. On a separate sheet of paper write the following:

      i. Your name, address and account number.

      ii. A description of the error and an explanation as to why you believe it is an error. If you only need more information, explain the item you are not sure about and, if you wish, ask for evidence of the charge, such as a copy of the charge slip. Do not send in your copy of the itemized statement unless you have a duplicate copy for your records.

      iii. The dollar amount of the suspected error.

      iv. Any other information which you think will help us identify you or the reason for your complaint or inquiry.

   (b) Send your billing error notice to: Patients' Accounts Department, Community Medical Center, 2827 Fort Missoula Road, Missoula, Montana, 59804. Mail it early enough to reach us within 60 days after the bill was mailed to you. YOU MAY TELEPHONE YOUR INQUIRY, BUT DOING SO WILL NOT PRESERVE YOUR RIGHTS UNDER THIS LAW NOR OBLIGATE US TO FOLLOW THE OUTLINED PROCEDURES.

2. We must acknowledge all letters pointing out possible errors within 30 days of receipt unless we are able to correct your bill within 30 days. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill is correct. Once we have examined the bill, we have no further obligation to you even though you still believe there is an error, except as provided in paragraph 5 below.

3. After we have been notified, **in writing,** neither we nor an attorney or collection agency may send you collection letters or take other collection action with respect to the amount in dispute, but periodic statements may be sent to you. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. **However, you remain obligated to pay the parts of your bill not in dispute.**

4. If we made a mistake on your bill, you will not have to pay any finance charges on the disputed amount. If we made no error, you may have to pay finance charges on the amount in dispute, and you will have to make up any missed minimum payments on the disputed amount. Unless you have agreed your bill was correct, we must send you written notification of what you owe; if we did make a mistake in billing, you must be given the time to pay which you are normally given as to undisputed amounts before any more finance charges on the disputed amount can be charged.

5. If our explanation does not satisfy you and you notify us **in writing** within 10 days after you receive our explanation that you still refuse to pay the disputed amount, we may report you to credit bureaus and may pursue regular collection procedures. But we must also report that you think you do not owe the money and inform you as to whom such reports were made. Once the matter has been settled, we must notify those to whom we reported you as delinquent of the subsequent resolution.

6. If we do not follow these rules, we are not allowed to collect the first $50.00 of the disputed amount and finance charges, even if the bill turns out to be correct.

Thank you.

Notice of Information / Privacy Practices
Acknowledgment of Receipt

It is the policy of Community Medical Center that each patient receives the Notice of Information/Privacy Practices upon the initiation of the treatment relationship. In the event of an emergency situation, the patient shall receive the Notice of Information/Privacy Practices in a reasonable amount of time. The Notice of Information/Privacy Practices shall be posted prominently on the Community Medical Center website.

This form serves to document that the Notice of Information/Privacy Practices was provided to the patient or the patient's representative.

☐ By signing this form, I acknowledge that I did receive the Community Medical Center Notice of Information/Privacy Practices.

☐ I have declined a copy of the Community Medical Center Notice of Information/Privacy Practices.

_____	_____	_____
Date	Time	Signature (patient or patient's representative)

If not signed, document good faith efforts to obtain acknowledgment:

_____

_____

_____

_____

Person seeking acknowledgment:_____ Date:_____