Hospital #: _______________

A&A – AUTHORIZATION TO BILL AND AUTHORIZATION TO RELEASE OF INFORMATION

(Consent for Financial Responsibility and Healthcare Operations)

University of Iowa Health Care (UI Health Care)
200 Hawkins Drive, HSSB Suite 100, Iowa City, IA 52242
Telephone: 866-393-4605; Fax: 319-356-2862; Email: him-consentform@uiowa.edu

Patient legal name: ____ **Birth date:** ___________________

University of Iowa Health Care (UI Health Care), for the purposes of this consent, includes all hospitals, provider offices, and other facilities providing healthcare services which are part of UI Health Care.

RELEASE OF INFORMATION FOR BENEFITS DETERMINATION AND PAYMENT: I specifically authorize UI Health Care to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, or other third-party payor or its authorized agents or representatives for the purposes of determining benefits and facilitating payment. This authorization includes information sharing with ambulance providers to facilitate billing and payment for patients transported to UI Health Care. This authorization allows release of past and future information and will expire after I am no longer a patient of UI Health Care, unless cancelled sooner by the patient or person legally authorized.

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I have been offered a copy of this authorization.

UI Health Care does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand the information may be released electronically and may include information in the following categories unless I specifically deny the release **(*check* any category *not* to be released)**. If you check any of the categories below, you may be billed directly instead of billing your insurance for services provided.

___ Substance use* ___ Mental health ___ HIV-related information ___ Genetic tests/info**

***Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). ****Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within UI Health Care, I consent to the program disclosing these records to others within UI Health Care and to other affiliates of UI Health Care for purposes of my treatment, quality improvement, other healthcare operations, and care coordination. This consent will expire after I am no longer a patient of UI Health Care. I may cancel this consent by contacting the Director of Health Information Management at the above address at any time except to the extent that the program, UI Health Care, or other UI Health Care affiliates have already acted in reliance on my consent.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third-party payers is correct. UI Health Care will use good faith efforts to protect the patient's right to confidentiality in appropriately providing health information to payors, including review for active coverage not previously communicated to UI Health Care in order to seek payment on behalf of the patient. I assign to UI Health Care, subject to acceptance, all benefits for care due to me under the terms of said policies and programs but, not to exceed the regular charges for similar services. I assign payment to the provider(s) rendering medical services and I assign payment for the unpaid charges of the provider(s) for whom UI Health Care is authorized to bill in connection with its services. I understand I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third-party payers.

I understand unless otherwise required by applicable law, UI Health Care does not accept assignment of benefits for third-party payer plans or reference-based pricing plans with which it does not contract. If UI Health Care is not contracted with my insurer or reference-based pricing plan, I understand I may be responsible for the charges associated with my care. I understand any partial payment UI Health Care may accept from a non-contracted third-

party payer or referenced-based pricing plan does not constitute an accord and satisfaction and is not an acknowledgment that UI Health Care accepts said payment as payment in full for any outstanding health care balances. I understand I may be billed the difference between charge and the amount my non-contracted insurer or referenced-based pricing plan is willing to pay. I understand I must pay all charges incurred if I lack insurance coverage and I may contact UI Health Care to work with them to identify financial options available for me. I agree to pay for non-covered services or services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor or agreed upon services deemed as medically unnecessary by the payor.

MEDICARE AND MEDIGAP AUTHORIZATION: I request payment of authorized Medicare and/or Medigap benefits be made on my behalf for any service furnished to me by UI Health Care, including provider services. I authorize any holder of medical and other information about me to release to Medicare and/or Medigap insurer and its agents any information needed to determine these benefits or the benefits payable for related services.

PAYMENT INFORMATION FOR EMPLOYMENT RELATED OCCUPATIONAL HEALTH SERVICES: I request UI Health Care and/or its affiliates to bill the employer for all associated costs for evaluation or treatment related to Occupational Health services and will submit claims on my behalf to our workers' compensation insurance carrier, if appropriate. I authorize disclosure of health information to the extent necessary to comply with employee/employer requirements to obtain payment for Occupational Health services.

PHOTOGRAPHY AND/OR VIDEO/AUDIO RECORDING: The people caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or video/audio recordings taken for these clinical reasons do not require your written permission. I acknowledge UI Health Care is an academic medical center which is constantly undergoing continuous improvement efforts as well as fulfilling its academic and teaching missions. I consent to having my image captured in a photograph, video, and/or audio format to be used for internal health care operations purposes. If UI Health Care intends to use captured photograph, video, and/or audio for purposes other than internal operational purposes, UI Health Care must obtain written authorization from me pursuant to applicable UI Health Care policy.

PERSONAL PROPERTY/VALUABLES: I understand UI Health Care recommends all personal belongings shall be sent home with a family member or friend. UI Health Care will not be responsible for the theft, loss, or damage of my personal property which includes, but is not limited to, money, jewelry, eyeglasses, dentures, hearing aids, garments, or other articles of unusual value. I understand there may be storage options available for my use. I assume full responsibility for all of my personal property and valuables and release UI Health Care from responsibility and liability for such items.

WIRELESS COMMUNICATION: I consent and authorize UI Health Care and its agents to:

- Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes I provided to UI Health Care at any time associated with me or my account;
- Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at UI Health Care or services received at UI Health Care in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
- Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by UI Health Care or services to be provided by UI Health Care in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I agree to immediately notify UI Health Care if any telephone number, email address, or other unique electronic identifiers or modes I provided to UI Health Care change or are no longer used by me.

NON-DISCRIMINATION: UI Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UI Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. UI Health Care provides free aids and services to people with disabilities to communicate effectively with UI Health Care, including:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, that includes qualified interpreters and information written in other languages.

If you believe UI Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Joint Office for Compliance, 200 Hawkins Drive, HSSB Suite 200, Iowa City, IA 52242, 319-353-8600, compliance@healthcare.uiowa.edu.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Joint Office for Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 800-868-1019, 800-537-7697 (TDD). Instructions for how to file a complaint are available at https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

I certify I have read this consent and by signing below, I represent the information given by me is accurate to the best of my knowledge.

Signature: ____ **Date:** ____________ **Time:** ___________
(Patient or person legally authorized to consent for patient)

____ _______________________________________
(Printed name of patient or legally authorized person signing) (Relationship to patient or legally authorized person)