OAK MEDICAL
ONSITE PHYSICIAN SERVICES

Consent for Treatment & HIPAA Acknowledgement

Consent for Services & Disclosing Health Information: I consent to evaluation and treatment services determined by physicians, advanced practice providers, or designees of Oak Medical to be necessary and advisable. I also consent to the use and disclosure of my health information by Oak Medical for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Oak Medical that may be involved in my care. Oak Medical may disclose my health information to, and access my health information from, other providers using a record locator service or patient information service of a health information exchange for treatment.

Insurance & Payment Consent: I authorize payments directly to Oak Medical of insurance, Medicare or Medicaid Assistance benefits, or funds from other sources that I am entitled to as payment for any services I have received. I consent to the use and disclosure of my health information for payment purposes. In addition, my insurer may share my past, current, and future health and account records with Oak Medical about services received from Oak Medical and care providers unrelated to Oak Medical. These records may be used by Oak Medical as needed to manage, coordinate, and improve my quality of care.

Notice of Privacy Practice: I acknowledge that I have received a copy of Oak Medical's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Oak Medical may change its privacy practices in the future, that any changes will be presented to me, and that I can request a new copy of the privacy practices at any time. I also understand that I can contact Oak Medical's main office with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Oak Medical's health care operations.

Use of Health Information for Trainings & Evaluations: I give Oak Medical permission to use and disclose information gathered during my treatment from Oak Medical, including information from my records, for the purposes of program evaluation, training, and/or quality review of staff performance at Oak Medical.

This consent applies to health information that Oak Medical already has about me, future care I may receive, and any information Oak Medical receives from third parties. This consent will continue unless I provide written notice to Oak Medical revoking consents, or when it expires by law. Revoking my consent only will apply *after the date* when the notice is received. It will not affect any information that was used or disclosed prior to the cancellation.

Full Name:_____ Date of Birth:_____/_____/ _____

Facility: _____

Patient's Signature (or legal representative) Date

(Relationship to Patient) Reason for Representation

Chronic Care Management (CCM) Program

This Medicare supported program is available to patients with 2 or more chronic conditions. CCM is considered to be a critical component of primary care that has been found to contribute to better outcomes and higher patient satisfaction.
Please consent to the following:

- There may possibly be a copay
- Patient can cancel the CCM program at any time
- Patient's Care Plan may be shared with other providers
- Only one practitioner per month can bill for the CCM Service

Please sign here to enroll in the program

Patient's Signature (or legal representative) Date

(Relationship to Patient) Phone # of Patient or Representative