Consent for Injury Care
Release of Information & Financial Policy Agreement

Employee Name:

DOB:

Employer:

Consent for Treatment & Release of Information

I consent to and authorize the examining Medical Provider (MD, DO, NP, PA, PT), and any associates to conduct physical exams and perform such tests and treatment as the examining physician deems necessary or appropriate. I also authorize personnel of the clinic to provide routine services requested by the Provider. The Provider will inform me as to the nature of any procedures, the alternatives to treatment and the risks that are involved. I will be given an opportunity to ask questions and have my questions answered. I understand that this consent to treatment is effective for the duration of my treatment for this injury unless revoked in writing by me.

I authorize OOM to disclose information regarding this injury to my employer and insurance carrier for the duration of my treatment as allowed by law, unless this release is revoked in writing by me. I hereby release the clinic employees and contractors from any liability from such disclosure.

Financial Policy & Patient Participation Agreement

We are committed to providing you with the best possible care. In order to achieve this goal we need your active participation in your care and understanding of our policies.

Worker's Compensation Fees and Process: Our fees are in accordance with Oregon's maximum allowable fee schedule. We will follow all applicable Oregon Administrative Rules* in accordance with these claims (OAR 436-009-000x). This includes submitting appropriate documents, billing and corresponding with the Worker's Compensation carrier (for your employer at the time of the injury/ illness). Similarly, you must submit the appropriate worker related forms and respond to requests for additional information from the insurer. Failure to do so could result in claim denial by the insurer. We request your social security number as it is used to identify your claim. Without this number your claim may be denied by the carrier.

Claim Acceptance or Denial: Oregon Law* allows the insurer sixty days to accept or deny your claim. In the event that your claim is denied, you have sixty days to appeal the decision (OAR 436-060-0140). If you do not to appeal or your appeal is not accepted, a final denial will be issued by the insurer. Once a final denial is issued, **you** are responsible for the charges incurred for the services we have provided. It is expected that you will pay the balance of your account in full within 90 days.

Personal Health Insurance: We do not bill Personal Health Insurance for any services we provide (effective 3/1/19). Your personal health insurance is a contract between you, your employer and the insurance company; we are not a party to that contract. You may choose to seek reimbursement from your personal health insurance for charges you pay to us. Our billing specialists can provide you with a superbill which includes the necessary information and insurance codes for you to submit to your insurer. We do not work with your personal health insurance directly. If you choose to seek reimbursement from them, the process is fully your responsibility.

Information Regarding Your Participation in Your Care: Healing requires a partnership between you and us. It is expected that you are an active participant in your care. If you do not show up for or cancel your scheduled appointments, we are obligated to inform your employer and your Worker's Compensation insurer. Repeated no shows or canceled appointments may negatively affect the status and compensability of your claim. After two missed appointments we may discontinue care of your injury.

I understand that in the event of a denial by the worker compensation carrier, after the appeal process is exhausted, I am personally responsible for the charges incurred. I understand that delinquent accounts may be assigned to a collection service and I will be charged for expenses, including any reasonable attorney fees. I understand in the event of a returned (NSF) check there will be a $30 minimum charge and payment will be required in the form of a credit card, cashier check or money order.

I have been given the opportunity to read the above Oregon Occupational Medicine policies and I agree to the terms above.

Patient Signature Date

OOM Employee Date

*Oregon Administrative Rules: http://tinyurl.com/y3nqkgbu (https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=75)

Optional: Release of Information

I authorize the staff of OOM to leave a message or send texts to this phone number:
or email me at the following address:

I authorize the staff of OOM to disclose information regarding my care (including appointment dates, times or medical information) to:

Spouse (name): Other (name/relationship):

This release is for the duration of my care for this injury or until I revoke this release in writing.

Patient Signature Date