OPTUM®

Patient registration II

Authorization to treat

I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Optum physicians and staff to provide such evaluation and/or care and treatments as an outpatient on a continuing basis and as an inpatient as necessary, as Optum physicians and staff may decide is advisable and necessary.

I understand that although care is reviewed and supervised by Optum physicians, actual care may be rendered by physician extenders (i.e. physician assistants, nurse practitioners, certified nurse midwife). I further understand that residents, medical students, physician assistant students, nurse practitioner students, nursing students, pharmacy students or other allied health professional students may assist in my treatment.

I am advised that such treatment may include physical examination, X-ray examination, laboratory procedures, other office procedures as well as inpatient procedures as required.

I understand that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with my Optum physician at any time.

Financial responsibility

I understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with Optum.

Assignment of benefits

I hereby assign medical and/or surgical benefits, private insurance, and any other health plan benefits to Optum. A copy of this assignment is considered valid as the original.

Acknowledgment of receipt of notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Cellular telephone number communications

By providing my cellular telephone number to Optum physicians on the Patient Registration 1 form, I agree to receive automated calls, prerecorded messages, and/or text messages related to my health care from Optum physicians and its affiliates. I acknowledge and agree that the text messages, which will be sent via unencrypted means, may contain Protected Health Information (PHI) and there is some risk of disclosure or interception of these messages.

I may revoke or withdraw this consent at any time. Withdrawal of consent for text messages can be made by replying STOP to the messages. Withdrawal of consent to receive automated calls and prerecorded messages must be made in writing.

Patient's signature Date

Patient's guardian/conservator or general agent Date

Relationship to patient/minor

OPTUM®

Authorization for release of health information

I authorize **Optum and its parent organizations** to use and disclose my individually identifiable health information between themselves for the purpose of providing me with better treatment, payment facilitation, care coordination and/or case management. Optum takes our patient's privacy very seriously and will only use this information as required and permitted under the law.

Type of information: I authorize these entities to use and disclose all of my health information including medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS*, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include information relating to visits, admissions, treatment, claims, case management or care coordination.

I understand and agree that:

- this authorization is voluntary;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- this authorization will expire two years from the date I sign it. I may revoke or modify this authorization at any time by notifying Optum in writing; however, the revocation/modification will not have an effect on any actions taken prior to the date my revocation is received and processed.

I certify that I have read the foregoing and have the right to request a copy. As the patient, the patient's guardian, conservator or general agent, I agree to accept the above terms.

Patient's signature _____ Date _____

Interpreter (if applicable)
See note of _____
Date

Patient's guardian/conservator or general agent _____ Date _____

Relationship to patient/minor _____ Date _____

**If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient.

*Special release needed for HIV test results.

Name: _____

Medical record number: _____

Date of birth: _____

Patient label