Clarii Health
MEDICAL MANAGEMENT

HIPAA & Disclosure for Authorization

Please check ***one*** below and write authorized names if yes:

_____ I **do not** authorize Clarii Health ("Provider") to disclose any information concerning my care or treatment by the Provider to any individuals (i.e., to my spouse, child, etc.) without my express written consent or legal authorization.

_____ I **do** authorize Provider to disclose information related to my care and treatment **to t*he following named individuals*,** should the need ever arise**:**

Name: **Phone number:**

1.
2.
3.

TREATMENT AUTHORIZATION: I authorize medical treatment of myself or my minor child by physicians and staff at Clarii Health.

HIPAA PRIVACY NOTICE & FINANCIAL POLICY
ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have been provided with the notice of privacy practices and financial policy and have been advised of how health information about me may be used and disclosed by Clarii Health and how may I obtain access to and control of this information. I fully understand the above information and have asked any questions that may have been unclear to me.

_____ _____ _____

Patient Name Patient Signature Date

Assignment of Benefits and Authorization to Release Medical Information

Clarii Health
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I understand and agree that payment of authorized benefits under any of my insurance carriers will be made to me or on my behalf to the provider/supplier of any services furnished to me by that person. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company (or the responsible person), & any information necessary to determine my benefits or benefit for the related services. If my insurance plan doesn't participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided to me by Privia, Dr. Selaru and its facility, I agree to be financially responsible and to pay charges for all services ordered by them. I understand that any balance due as a result of being uninsured /underinsured is due immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in a reduction or denial of benefit payment.

Consent to Treatment

As a patient, I voluntarily consent to the rendering of such care that the doctor & facility, in their professional judgment, deem necessary for my health and well-being. My consent shall include medical examination and testing (including testing for STD's, Drugs, and/or HIV, if separate consent is not required by law), including, but not limited to, injections/IV's, minor surgical procedures (e.g., suturing) and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any staff has made any guarantee as to the results that may be obtained.

If I schedule a telehealth visit (a "virtual visit'), I hereby consent to participate in such a telehealth visit & understand I may terminate it at any time. I understand telehealth visits are billed to my insurance, or self- pay, whichever arrangement I have set forth prior. I understand it is not a free service.

My consent shall cover the use of recording devices for the purpose of scribing and clinical documentation improvement. All recording adheres strictly to Health Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

Consent to Call/Text/Mail

I understand and agree that Privia may contact me using automated calls, emails, & text messaging sent to my landline and mobile device. These communications may notify me of appointments, test results, treatment recommendations, outstanding balances, or any other communications. I also consent to be notified of outstanding balances, test results or other communications via the U.S Postal Service. I understand that I may voluntarily "opt-out" of receiving automated phone call communications from Privia & its partners by informing my provider's staff directly.

I hereby acknowledge that I have received Privia's Financial Policy and Notice of Privacy Practices. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers. To be signed by a patient's parent or legal guardian if the patient is a minor or otherwise not competent.

Printed Name of Patient: _____ **Signature:** _____ **Date:** _____