AOW
Mobile Anesthesia

PATIENT INFORMATION

Patient Full Name: _____

Birth date: _____ Gender: _____ Social Security #: _____

Contact Phone: _____ Alternate #: _____

Address: _____ City/State: _____ Zip: _____

Email: _____

I agree that AOW may communicate electronically at the email address above. I am aware there is some level of risk that third parties might be able to read unencrypted emails. I can withdraw this consent at any time by submitting a written request. Signature/Date: _____

Name/Phone of Emergency Contact (to wait at dental office): _____

Dental Insurance Information:

Primary Insurance Company: _____ ID or SSN #: _____

Name of Policy Holder: _____ Birthdate: _____

Ins. ID or SSN #: _____ Relationship to Patient: _____

Employer Name: _____ Plan Name: _____

Insured's Address (if different from patient): _____

Insurance Phone: _____ Group #: _____

Secondary Insurance Information:

Secondary Insurance Company: _____ ID or SSN #: _____

Name of Policy Holder: _____ Birthdate: _____

Ins. ID or SSN #: _____ Relationship to Patient: _____

Employer Name: _____ Plan Name: _____

Insured's Address (if different from patient): _____

Insurance Phone: _____ Group #: _____

OFFICE USE ONLY:

Name of Office: _____ **Date Scheduled:** _____

Length of anesthesia: _____ Dental Procedure: _____

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CONSENT FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

PURPOSE: This form is provided to obtain consent for AOW to use and disclose the individual's protected health information for the purpose of treatment, payment, and health care functions.

Individual giving Consent: By signing this form, I authorize AOW to use and/or disclose protected health information (PHI) as follows:

- To provide and coordinate my treatment among other health care providers or staff who may be involved in my medical/dental treatment directly or indirectly
- To patient's family, friends, and other individuals who are involved in your health care
- To third-party payers, collectors, or arbitrators for the payment, or collection, of patient's health care services

Notice of Right to Decline Disclosure Consent: You have the right to refuse to sign this authorization. However, if you decide not to sign this consent, we may decline to treat you. When your information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This consent will remain in place until we receive written request to remove consent. You have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization prior to revocation. My written revocation must be submitted to:

Anesthetists of Washington, LLC
6602 Appleview Rd, #1
Yakima, WA 98908

OPTIONAL: I give AOW permission to share my health information and have discussions with:

Name of Person _____ Relationship _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: AOW keeps a record of the health care services provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by Federal law and RCW 70.02.120. By signing below I confirm that I have been informed of AOWs Notice of Privacy Practices. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that AOW has the right to change the Notice of Privacy Practices and that I may contact this office as the address above to obtain a current copy of the Notice of Privacy Practices.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Legal Guardian or Representative

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Patient Payment Agreement
(ALL Patients Must Sign)

I request that payment of authorized Medicare, Medicaid **and/or** other insurance benefits be made on my behalf to **Anesthetists of Washington, L.L.C., dba AOW, or provider** for any services furnished to me by the aforementioned provider. I authorize any holder of medical information about me to release to Medicare, Medicaid **and/or** any other insurance company and its agents any information needed to determine these benefits payable for related services. **I understand that billing my insurance company is a courtesy and not an obligation of this service.**

I agree that the patient pay-up-front discounted amount is due at or before time of service. I further agree that I am liable for all charges whether or not insurance payments are pending or possibly forthcoming or if my insurance company denies payment to **Anesthetists of Washington, L.L.C. dba AOW, or provider.**

I agree to provide **Anesthetists of Washington, L.L.C., dba AOW, or provider,** with proper insurance and/or workman's compensation information at time of service. I understand if I fail to do so, I am responsible for all charges incurred.

In the event that my account becomes past due, (unpaid after ninety (90) days of the initial billing, and I have failed to respond to a final notice) the account may be referred to a collection agency. I agree to pay 1% simple interest per month, and 12% simple interest annually on any unpaid balance as of the last date of service. I further agree that there will be a **$35.00 fee** for all returned checks.

_____ _____
Signature of Patient and/or Legal Guardian Date

MEDIGAP AUTHORIZATION (for Medicare Secondary policy patients and patients with secondary insurance) I authorize any holder of medical or other information about me, to release to any Medigap payor or other secondary insurance, as listed in my chart, any information needed for this or a related Medigap or other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be assigned to **Anesthetists of Washington, L.L.C. dba AOW, or provider,** who accepts assignment.

_____ _____
Signature of Patient and/or Legal Guardian Date

MEDIATION AGREEMENT: PATIENT-PROVIDER: We encourage open communication and ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or interference to a "claim" will be understood and read as "potential claim" until the mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

_____ _____
Signature of Patient and/or Legal Guardian Date