Optum

American Health Network
Part of Optum®

Appointment date: _____

Appointment time: _____

Provider: _____

Welcome, and thank you for choosing American Health Network, part of Optum for your primary care needs.

We believe health care should be a partnership between you and your providers. We're dedicated to working with you to get you as healthy as possible and quickly take care of your needs.

When you need us, you need us. We offer same-day sick appointments, so you can be seen as quickly as possible. We'll schedule you with the first available provider if your primary care provider isn't available in our office or for a video visit.

To help your first appointment run smoothly, please bring your:

- Completed paperwork (forms are included with this letter)
  - > The "Authorization to Release Medical Records to AHN" form gives your last provider permission to send us your medical records.
- Current insurance card(s), if applicable
- Photo ID (a driver's license, state ID card or student ID card)
  - > Anyone under age 18 must come with a parent or guardian for routine care appointments. If you're under age 18 and don't have a photo ID, your parent or guardian must show their photo ID at the visit.
- All current prescriptions, vitamins and supplements in their original bottles

Please note: Our providers might not be able to prescribe controlled substances during your first visit. You will be able to talk about future medicine options with your provider.

Please be sure to read our financial policy (included with this letter) for information about insurance billing, patient billing and self-pay discounts and programs.

Our office will call to remind you about appointments at least 48 hours in advance. If you need to cancel or reschedule, please let us know when we call. Or, you can call our office at least 24 hours in advance.

If you have any questions about the attached forms or any of our policies, please call your primary care provider's office.

You have choices when it comes to your health care, and we thank you for choosing us! We are honored to join you on your personal health journey. We look forward to working with you and providing high-quality care for years to come.

Patient Registration Form

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Patient last name: _____ First name: _____ Middle name: _____

Preferred name/nickname: _____ DOB/age: _____ SSN: _____

Home address: _____

Home phone: _____ Cell phone: _____ Preferred phone: _____

Email address: _____

Sex. gender, race, ethnicity and language: We would like you to provide us with your sex, gender, race and ethnic background. We will only use this information in medical decision making to help in understanding possible risk factors.

Birth Sex: ☐ Female ☐ Male ☐ Undifferentiated ☐ Unknown

Gender Identity: ☐ Choose not to disclose ☐ Female ☐ Female-to-male (FTM)/transgender male/trans man

☐ Gender queer ☐ Neither exclusively male nor female ☐ Male ☐ Male-to-female (MTF)/transgender female/trans woman

☐ Additional gender category or other, please specify: _____

Which category best describes your race? ☐ Decline to specify ☐ American Indian or Alaska Native

☐ Black or African American ☐ White ☐ Asian (includes Pakistan or Indian origins) ☐ Other

Which best describes your ethnicity? ☐ Decline to specify ☐ Hispanic ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Not Hispanic or Latino

What language do you feel most comfortable speaking with your healthcare provider? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed ☐ Decline to Answer

Patient's employer: _____

Corporate address: _____ Phone: _____

Emergency contact name: _____ Relationship: _____ Phone: _____

Person responsible for bill or parent *(complete only if different than patient)*:

Responsible party: _____ DOB: _____ SSN: _____

Relationship to patient: ☐ Spouse ☐ Parent ☐ Other

Address: _____ Phone: _____

Responsible party's employer: _____

Corporate address: _____ Phone: _____

Primary insurance:

Name of insurance company

Address of insurance company *(listed on back of card)*

Phone number for insurance company *(listed on back of card)*

Name of insured *(person carrying insurance on patient)*

Insured's place of employment

Employers corporate address

Employers phone

Insured relationship to patient, policy #, group #

Secondary insurance:

Name of insurance company

Address of Insurance Company *(listed on back of card)*

Phone number for insurance company *(listed on back of card)*

Name of insured (person carrying insurance on patient)

Insured's place of employment

Employers corporate address

Employers phone

Insured relationship to patient, policy #, group #

Is your visit related to a job-related injury or automobile accident? ☐Y ☐N

IF YES PLEASE NOTIFY FRONT DESK STAFF.

Please note: ***It is the patient's responsibility to immediately notify American Health Network, Part of Optum if there are any changes to the information on the form - especially if there is a change in address and/or guarantor.***

Signature

Date

Patient History Form

Optum

American Health Network
Part of Optum®

Patient last name: _____ First name: _____ Middle name: _____

Date of birth / age: _____ Veteran : ☐ Yes ☐ No

Previous or referring provider: _____

Please describe any current problems you are experiencing: _____

Past medical history *(check any you have or have had)*:

- ☐ Headaches/migraines
- ☐ Glaucoma
- ☐ Sinus problems
- ☐ Heart disease
- ☐ Pacemaker/defibrillator
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Poor circulation
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Heartburn/GERD
- ☐ Constipation/diarrhea
- ☐ Liver/gallbladder problems
- ☐ Hepatitis A B or C
- ☐ Kidney disease
- ☐ Bladder disease
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Epilepsy/seizures
- ☐ Bleeding disorder
- ☐ Blood clotting disorder
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Diabetes
  # of Years _____
  - ☐ *diet control*
  - ☐ *oral med*
  - ☐ *insulin*
- ☐ Thyroid disease
- ☐ Psychiatric disorder
  - ☐ *Schizophrenia*
  - ☐ *Bipolar*
- ☐ Anxiety/depression
- ☐ Chemical dependency
- ☐ Cancer
  Type _____
  Age at onset _____
- ☐ Sleep apnea
- ☐ Rheumatic fever
- ☐ Other _____

Details of any of the above:

Past surgical and hospitalizations:

Date of procedure or hospitalization	Name of procedure	Reason for procedure or hospitalization	List any procedure complications

Family History:

Relative	Condition	Age of onset	Cause of death? Y/N
Father			
Mother			
Paternal grandmother			
Paternal grandfather			
Maternal grandmother			
Maternal grandfather			
1. Brother or sister			
2.			
3.			
4.			
1. Son or daughter			
2.			
3.			
4.			
Significant other			

Social History:

Smoking: ☐ Yes ☐ No ☐ Quit Packs per day?_____
How long? _____ If quit, when? _____
Vaping/e-cigarette: ☐ Yes ☐ No ☐ Quit
How long? _____ If quit, when? _____
Chewing tobacco: ☐ Yes ☐ No ☐ Quit
How long? _____ If quit, when? _____

Alcohol use: ☐ Yes ☐ No ☐ Quit
Number drinks per week? _____ Type of alcohol? _____
If quit, when? _____
Narcotic drug abuse: ☐ Yes ☐ No
Recreational Drug Use: ☐ Yes ☐ No

Medications:

List current medication or supplement	Dose (i.e. 250 mg)	Frequency (i.e. once per day)	Why was the medication prescribed (i.e. back pain)	Local pharmacy	Mail order pharmacy

Allergies:

Allergen/medication	What is your reaction to the allergen/medication?

Patient name *(please print)* _____ Signature of patient, parent, or legal guardian _____ Date _____

General Consent Form

Consent to Treat
I hereby consent to American Health Network, LLC, part of Optum, including all of its divisions and clinical staff providing and performing such medical care, tests, procedures, and other services deemed necessary or beneficial for my health and wellbeing. I understand that to ensure quality and continuity of care, all American Health Network, LLC, part of Optum providers may have access to my electronic health record and will access as necessary for my medical care. The duration of this consent is indefinite and continues until revoked in writing.

Assignment of Insurance Benefits and Financial Responsibility
I hereby authorize and assign payment of medical benefits directly to American Health Network, LLC, part of Optum (hereinafter "AHN"). I authorize medical information needed to determine these benefits or the benefits payable for the related services be release to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payments and it is due upon request. I have been given a copy of AHN's "Patient Financial Policies, Terms and Conditions" (contained within this new patient packet) and have reviewed said document. The duration of this consent is indefinite and continues until revoked in writing. I understand that by signing below that I am responsible for payment of services in full.

Consent to Communication
Telephone, Voice Messages & Text Messaging Communications: By providing my telephone number to American Health Network, LLC, part of Optum on the Patient Registration Form, I agree to receive automated calls, prerecorded messages, text messages and/or voice messages for return calls and appointment reminders from American Health Network and its affiliates and understand that message and data rates may apply. Text messaging is not a secure method of communication and carries some risk of being read by a third party; for help reply "HELP" and to opt-out of text messaging at any time, reply "STOP". Go to **https://www.optum.com/ care-text-terms.html** to read Optum's Texting Terms of Use. I may revoke or withdraw this consent at any time by contacting customer service at **1-888-255-2246, TTY 711.**

Email & Postal Mail Communication: By providing my e-mail and postal mailing address on the Patient Registration Form, on other AHN forms and or through other channels of communication to American Health Network, part of Optum, I agree to receive e-mail messages and postal mail related to treatment, research, marketing, education, etc., from American Health Network, part of Optum and its affiliates. To stop receiving e-mails at any time, I may click "unsubscribe" at the bottom of the e-mail. To stop receiving postal mail, please contact customer service at **1-888-255-2246, TTY 711**. American Health Network, part of Optum may send PHI to me, by mail, text message or email, in an unencrypted manner. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

If you do not wish to be contacted via the contact information and communication method you provided on the AHN Patient Registration Form, provide an alternative method through which American Health network should contact you:

_____

By signing below, I acknowledge that I have reviewed this form and understand its contents.

_____ _____
Patient Name *Patient Date of Birth*

_____ _____
Signature of Patient or Legal Representative *Date*

_____ _____
Legal Representative's Name *Relationship to Patient*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and FINANCIAL POLICY

By signing below, I acknowledge that I have received a copy of the Provider Notice of Privacy Practices and Financial Policy.

_____ _____
Patient Name *Patient Date of Birth*

_____ _____
Signature of Patient or Legal Representative *Date*

_____ _____
Legal Representative's Name *Relationship to Patient*

American Health Network, part of Optum
Patient Financial Policies
Terms and Conditions

Payment guarantee: For services provided by American Health Network, part of Optum ("AHN"), you guarantee payment of your account at the time services are provided for any and all costs that are not paid by an insurance carrier, government plan (including Medicare and Medicaid), or other third-party health plans (together, referred to as "Health Plan"), including if your Health Plan denies a claim after first approving it. You acknowledge that you will be responsible for paying AHN for items and services provided to you or your dependents under these Conditions whether or not you are listed as the "Responsible Party" on the Patient Data Sheet. The person listed as the "Responsible Party" on the Patient Data Sheet will also be responsible to AHN for payment. All charges incurred are your responsibility.

Out of network referrals: An out-of-network provider may be called upon to provide health care items or services to a covered individual during the course of treatment. Out-of-network providers are not bound by the payment provisions that apply to health care items or services rendered by an in-network provider under a covered individual's Health Plan. You should contact your Health Plan before receiving health care items or services by an out-of-network provider to get a list of in-network providers that may provide the health care items or services, as well as additional resources. You understand that any out-of-network charges are your responsibility as determined by your Health Plan.

Physician investments: Be advised that AHN physicians may refer you to a health care entity (an organization or business that provides diagnostic, medical or surgical services, dental treatment or rehabilitative care), in which the physicians have a private/individual investment, including, but not limited to: American Health Network, Knox Diagnostic Imaging Center, LLC, Damon Dialysis, LLC, Eagle Highlands Surgery Center, LLC, Beltway Surgery Centers, LLC and various other surgery centers. Patients are advised that in each case they may choose to be referred to another health care entity. Your signature on the General Consent Form acknowledges you have received this notice of physician investment(s).

Assignment of benefits: To the extent there is Health Plan coverage for payment of services, you agree that all medical and related benefits PAID by the Health Plan will be irrevocably assigned to AHN on your behalf.

Billing information: You agree to provide complete and accurate information and notify us of changes to any of your information (address, phone number, insurance, including Guarantor information. If you do not update your insurance information, we will not be responsible for any misdirected correspondence mailed to an outdated mailing address or addressed to an outdated contact person.) We will use reasonable efforts to submit claims to your Health Plan and promptly provide you with our statements. If for any reason, amounts that you owe are not paid promptly, including if a statement is returned as undeliverable, you may be referred to a collection agency. Bring your government-issued photo identification and insurance cards to every visit. Otherwise, you may be required to pay in full that day.

Medicare agreement: If you have Medicare coverage, you acknowledge that payment of benefits will be made to you or on your behalf for any items or services provided to you by AHN (or the party who accepts assignment), including your physician services. You authorize any holder of medical or other information about you to release to Medicare and its agents, any information needed to determine these benefits or any benefits for related services.

Payment terms: We require payment at the time of your office visit. This includes amounts for co-pays, coinsurance, deductibles and past due balances unless previous arrangements have been made with our billing department. If you fail to make payment at the time of service, we may charge extra processing fees in recognition of billing and collection expenses.

Billing payers: We will file your claims with your Health Plan after services are provided as a courtesy. If your Health Plan pays you directly, you are responsible for payment in full to AHN. We may estimate what your Health Plan will pay, but the Health Plan decides your eligibility and benefits. It is your responsibility to understand what services are covered by your Health Plan. You will be fully responsible for paying for services or amounts that are not covered. Contact your Health Plan before a service is provided if you have questions about coverage. You may submit to us a written request NOT to disclose your medical information about a specific service to your Health Plan, if you pay for that particular service in full at the time it is rendered. The form that patients should complete is *AHN_PatientForm.011.2022 "Patient Request to Restrict Uses and Disclosures of PHI to Health Plan".*

AHN will select the codes that are used in billing based on Health Plan policies and industry standards. Health Plans make payment decisions based on the coverage policies for your insurance policy. Example: If you come in for a sports physical, AHN codes it as a sports physical. If your Health Plan does not cover sports physicals, you will be responsible for paying. AHN cannot change the reason for the visit. It is you or your dependents responsibility to notify us if/when the dependent turns 18 and/or when the parent is no longer responsible for the dependent's medical expenses.

The amount that your Health Plan requires you to pay may depend on whether other providers bill separately for part of the service. The amount you are required to pay may also depend on whether the service is preventative (i.e., you have no symptoms suggesting a problem) or diagnostic (i.e., you have symptoms). If you have a preventative screening scheduled, but show up at the appointment with symptoms, your provider will discuss with you the need for any diagnostic services because diagnostic services may be billed separately from your preventative screening. This may result in you having to pay more, such as a higher co-insurance. AHN will always follow the billing requirements of your Health Plan.

Your Health Plan may require prior authorization or referral for some services. Obtaining authorization or referral does not guarantee that your Health Plan will pay. You are responsible for ensuring that authorizations and referrals are obtained prior to receiving services. Please call our Billing Department if you have difficulty with your Health Plan, and we will try to assist.

You are responsible for payment until the account is paid in full. It may take time for AHN to resolve payment with your Health Plan (i.e., processing delays, misplaced claims, requests for additional information and appeals). You are responsible for cooperating with requests for additional information and assistance with appeals. AHN may wait until your Health Plan officially notifies us of the amount that you owe or until disputes about how much your Health Plan owes are resolved, before sending a statement to you. Payment is expected by the due date contained on our statements.

If AHN is contracted with your Health Plan, the terms of that contract will be followed. If there is a conflict between your Health Plan’s contract and AHN’ s Financial Policies, AHN will follow the terms of your Health Plan. If AHN is not contracted with your Health Plan or AHN is unable to verify that your Health Plan will be responsible for payment, you may be required to pay in full at the visit.

Interest and attorney's fees: For any past due amounts, AHN has the right to apply interest to any remaining balance. The interest rate shall be 1.5% per month (18% per year), & you shall be responsible for all costs and expenses incurred in efforts to collect past due amounts from you, including interest charges, court costs and reasonable attorney's fees. If a check is returned for insufficient funds, all charges incurred by AHN shall be your responsibility.

Note to parents or guardians of dependents: The Billing Statement for your child will be sent to you, and you are responsible for paying AHN. If you believe that someone else is responsible for the child’s medical expenses, you may take action against that person to recover the amounts for which they are responsible, however, you remain responsible to make the payment to AHN when it is due.

Workers’ Compensation injury: If you believe you are being seen for an injury/illness as a result of your job, you need to provide written authorization from your employer to confirm work-related injury and designation of Workers’ Compensation Injury coverage, with direction from your employer on how AHN should bill. If you do not provide this information at the time services are provided, AHN may bill you and/or your insurance company.

Self-pay services: If you do not have insurance or if the services are not covered by your Health Plan, AHN will provide an advanced cost estimate of the services, a waiver form and up to a fifteen percent (15%) discount for professional services (includes office visits, virtual visits, procedures and imaging; excludes CDL/sports physicals, labs, screening services, immunizations and supplies) rendered. The self-pay discount is only applied if payment is made in full at the time services are rendered. This discount does not apply to any service covered by a Health Plan, Workers’ Compensation, Occupational Health Services or owed due to co-pays, coinsurance or deductibles.

Patient Financial Policies, Terms and Conditions

Payment options: If you are unable to meet your financial obligations, payment arrangements can be made. Financing options may be available. Contact our Billing Department to discuss payment options before your account becomes overdue. In cases of financial hardship, ask about the clinic's Hardship Policy. Hardship policies vary by clinic; limitations and restrictions apply.

Making payments: Patients may pay by cash, money order, check or personal credit card. This includes cards for flexible spending accounts (FSA) and/or health savings accounts (HSA). With patient approval, HSA card information may be kept on file by AHN to facilitate billing. If you have a credit balance, AHN may apply it to any outstanding balances on your HSA account or the accounts of your dependents. Some locations may restrict payment by cash or check.

Fees assessed by AHN: You may be charged fees for: (1) returned checks, (2) completion of forms (e.g., disability or family medical leave), and (3) copies of medical records.

Termination of services: If you fail to keep your account current or fail to respond to three (3) notices to the address we have on file for you, you agree that AHN may terminate your relationship with any or all of our offices (see AHN Dismissal Policy). In such an event, you agree that you are no longer a patient, and AHN will not offer you a future appointment. You will have deemed yourself as terminating our relationship if you do not obtain services from AHN for three (3) years or if you notify us that you will no longer be a patient. Acceptance back into the practice is at the discretion of AHN. AHN may terminate your relationship with us for other reasons, such as disruptive behavior or non-compliance with care plan.

Accidents and motor vehicle injuries: AHN's providers have the discretion to decide whether or not to see patients injured in motor vehicle accidents or for other liability injuries. AHN's providers also have discretion to decide whether or not to bill the liability insurance involved (i.e. home, auto, etc.). AHN does not have to agree to subrogate or accept liens. You must provide accurate information about the injury and may be required to complete an injury questionnaire. In all cases, you bear responsibility for the costs of your care and must pay them promptly at any time that AHN decides, which may include requiring payment in full at time of service.

Continuing agreement: I have read this information carefully and agree that everything in this Agreement applies to current and future health care services provided by AHN. I acknowledge that AHN may make changes to these terms without my consent. AHN will provide notice of any material changes to these terms, but it is my responsibility to read the notice carefully because the changes will apply to the health care services provided by AHN.

I have read and understand the Payment Policy and agree to abide by its guidelines:

_____	_____
Print name of patient or responsible party	**Date of birth**
_____	_____
Signature of patient or responsible party	**Date**

PROVIDER NOTICE OF PRIVACY PRACTICES

NOTICE FOR MEDICAL INFORMATION: Pages 4 – 9

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Language Assistance Services

We[1] provide free language services to help communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **toll-free 1-888-696-9637, press 0. TTY 711**. We are available Monday through Friday, 8 a.m. to 5 p.m. ET.

1	Spanish	Tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para solicitar un intérprete, llame al 1-888-696-9637 y presione el cero (0). TTY 711
2	Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-888-696-9637，再按 0。聽力語言殘障服務專線 711
3	German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die Nummer 1-888-696-9637 an und drücken Sie die 0. TTY 711
4	Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwesetzer hawwe witt, kannscht du 1-888-696-9637 uffrufe, dricke 0. **TTY 711**
5	Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင့်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန် တစ်ဦးတောင်းဆိုလိုပါက 1-888-696-9637 သို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
6	Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل بالرقم [1-888-696-9637، واضغط على 0. الهاتف النصي (TTY) 711
7	Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는1-888-696-9637로 전화하여 0번을 누르십시오. TTY 711

8	Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi 1-888-696-9637, bấm số 0. TTY 711
9	French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le 1-888-696-9637 et appuyez sur la touche 0. ATS 711.
10	Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、1-888-696-9637までお電話の上、0を押してください。TTY専用番号は 711です。
11	Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel 1-888-696-9637, druk op 0. TTY 711
12	Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tumawag sa 1-888-696-9637, pindutin ang 0. TTY 711
13	Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по телефону 1-888-696-9637 и нажмите 0. Линия TTY 711
14	Panjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ 1-888-696-9637 ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
15	Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए 1-888-696-9637 पर फ़ोन करें, 0 दबाएं। TTY 711
16	Cushite	Kaffaltii alla afaan keessaniin odeeffannoo fi deeggarsa argachuuf mirga ni qabdu. Nama afaan hikuu argachuuf, lakkoofsa bilbilaa 1-888-696-9637 tiin bilbilaa. 0 Tuqii. TTY 711
17	Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama 1-888-696-9637 e premi lo 0. Dispositivi per non udenti/TTY: 711
18	Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, задзвоніть на 1-888-696-9637, натисніть 0. TTY 711
19	Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la 1-888-696-9637, apăsați pe tasta 0. TTY 711

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Email: **Optum_Civil_Rights@Optum.com**

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **toll-free 1-888-255-2246.** TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 5 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices. Please note that not all entities listed are covered by this Notice.]

Medical Information Privacy Notice

Effective January 1, 2023

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website https://www.ahni.com. If we maintain a physical delivery site, we will also post a copy in at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may collect, use and disclose your health information:

- **For Payment.** We may collect, use, and disclose health information to obtain payment for health care services. For example, we may collect information from, or disclose information to, your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect,

information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice, and we may use it for any lawful purpose.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Reminders.** We may collect, use, and disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases;
    5. Genetic Information

6. HIV/AIDS
7. Mental Health
8. Minors Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled “Exercising Your Rights.”

What Are Your Rights
The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept

your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, https://ahni.com or by calling 1-317-580-6309 or Toll-free1-888-255-2246.

Exercising Your Rights

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call **American Health Network part of Optum at** 1-317-580-6309 or Toll-free1-888-255-2246 or send an email to Privacy@optum.com.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

American Health Network Part of Optum
Attn: Privacy Department
7440 Woodland Drive
Indianapolis, IN 46278

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

  American Health Network Part of Optum
  Attn: Privacy Department
  7440 Woodland Drive
  Indianapolis, IN 46278

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2] This Medical Information Notice of Privacy Practices applies to the following providers that are affiliated with Optum, Inc: American Health Network part of Optum.

Authorization to Release Medical Records TO American Health Network

(This form can be used if another healthcare provider requires written patient authorization to obtain patient records needed by AHN)

I. RECORDS TO BE RELEASED FROM NON AHN PROVIDER:

Name of HealthCare Provider: _____

Address: _____
Street City State Zip

II. RECORDS TO BE RELEASED TO AMERICAN HEALTH NETWORK:

I hereby request and authorize the above named Healthcare Provider **to release my records to:**

Doctor_____ of American Health Network ("AHN") located at address:

_____
Street City State Zip

Telephone #_____ Fax#_____

III. THE RECORDS OF (Patient name):

Last _____First_____MI_____

Date of Birth: _____ **ONLY LAST FOUR (4) DIGITS OF SS#:**_____

Address: _____
Street City State Zip

Telephone #: _____Fax#: _____

IV. RECORDS TO BE RELEASED:

a) Please release the following information (check those that apply):

☐ Provider notes	☐ X-ray reports
☐ Special Diagnostic test results	☐ Chemical/Alcohol Treatment records
☐ Lab reports	☐ **ALL Medical Records**
☐ Billing records	☐ Other (specify)

b) **SPECIAL AUTHORIZATION:** **Unless I HAVE LIMITED BELOW**, I understand that the release of records also pertains to those records regarding testing and treatment **for alcohol/substance abuse**, **human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease.** By putting a check mark below and signing this form, I authorize AHN to release records about me pertaining to: (**Indicate BELOW):**

☐ **Alcohol, Drug, or Substance Abuse**	☐ **Communicable disease.**
☐ **Human immunodeficiency virus (HIV) and/or AIDS,**	☐ **Genetic**
☐ **Psychiatric treatment or counseling**	☐ **Other:**

I UNDERSTAND (1) AHN will not condition treatment, payment, enrollment, or eligibility for benefits on this whether I sign this authorization.(2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE. (3) THAT THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, (4) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION, and (5) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT.

Date_____ Patient Signature_____

Expiration (if none, at 60 days): _____ Signature if other than patient:_____
(Parent/Guardian/Legal Representative, if patient unable to sign- Relationship)

Optum

American Health Network
Part of Optum®

AHN_PatientForm.007a.2022

Individual Rights: Request for Medical Records

Patient/Guardian Authorizations to Disclose Protected Health Information to Others

Patient Name: _____**DOB:**_____ **Today's Date:** _____

Primary Care Provider: _____

AHN Location: _____

To the patient: American Health Network will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. This form will be used at all AHN locations. Please note that AHN does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.

Authorization given by: **Patient** **Patient Representative** *(AHN must have evidence of legal representation)*

American Health Network may disclose **ALL** of my Protected Health Information* (*including that about alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or information related to psychiatric treatment or counseling, and related to communicable disease,* ***unless I limit below***) **to:**

	Name	Relationship	Contact info (phone/address)	May AHN give this person access to your NextMD Patient Portal? Y/N
1				
2				
3				

*** Limitation - The following checked information may NOT be disclosed to any of the above**:

Alcohol, Drug, or Substance Abuse	**Communicable disease.**
Human immunodeficiency virus (HIV) and/or AIDS,	**Genetic**
Psychiatric treatment or counseling	**Other:**

Duration/Expiration: ONLY the most recent signed DISCLOSURE AUTHORIZATION will be honored. This Authorization will stay in effect during my treatment at AHN unless it is revoked/revised by me in writing. I agree that AHN is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information. This authorization is solely for disclosure of my information as indicated above. **It is NOT an authorization to individuals listed above to make medical treatment decisions on my behalf.**

Patient/Guardian Signature:_____**Date**:_____

Provide copy to the patient at his/her request.