Advanced Laboratory Services - Phone: 855-238-4949

Release of Information & Consent for Treatment

Patient Name (Last, MI, First) _____ Patient Account #_____

1. PATIENT SELF DETERMINATION ACT AND BILL OF RIGHTS: I acknowledge I have received a written statement of my rights as a patient of Advanced Laboratory Services I understand my rights because they have been explained to me and my questions have been answered. I have received information about company policy, applicable state law, my rights under state law.

2. RELEASE OF INFORMATION: I consent to the release of information by my Physician, Licensed Health Care Professionals, or Facility ("health providers"), and to allow the disclosure of medical records kept by my health providers to Advanced Laboratory Services I consent to the release of information by Advanced Laboratory Services or its representatives to representatives of health providers involved in my care, survey and accrediting bodies, and to third party payers from which the company is seeking reimbursement for services/supplies provided to me.

3. CONSENT FOR TREATMENT: I voluntarily consent to allow treatment from Advanced Laboratory Services consistent with a medical treatment plan authorized by my physician. I understand that if I am in such condition as to need services not provided by Advanced Laboratory Services, I or my legal representative, or my physician must arrange such services. Advanced Laboratory Services shall assist in locating such services, but shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood or body fluids, I give permission for my blood to be tested for infectious diseases such as HIV and Hepatitis. I understand that the exposed employee will be informed to the results of the test. I understand that I will not be billed for any lab fees incurred should an employee sustain exposure to my blood.

4. SERVICES TO BE PROVIDED: My physician has ordered the following services:
   ☐ Lab

5. PAYMENT AUTHORIZED AND ASSIGNMENT OF BENEFITS: I hereby authorize my insurance provider to make payment directly to Advanced Laboratory Services for authorized services provided. In consideration of Advanced Laboratory Services's agreement to forego collection of my account for a reasonable period of time. I hereby assign to Advanced Laboratory Services or its legal representative, all of my rights, including the right to sue on my behalf or name to recover charges for services rendered by Advanced Laboratory Services This assignment shall not extinguish or diminish my obligation to pay the full fee to Advanced Laboratory Services for services rendered. If I fail to make full payment or comply with the assignment provisions, in addition to all other amounts I have agreed to pay, I will pay Advanced Laboratory Services all expenses it incurs, including reasonable attorney's fee, to enforce its right to collect its full fee. I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan it is my responsibility to notify Advanced Laboratory Services, otherwise I will be responsible for payment.

6. I understand that my insurance has agreed to pay _____% of allowable charges and that my secondary insurance (if applicable) will be billed for _____%. I understand that I am responsible for _____% of allowable charges after my deductible has been met. My **approximate** out of pocket cost will be: $ _____ / Copayment $ _____ .

Patient or Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Please explain if someone other than patient signs: _____

BILL OF RIGHTS AND RESPONSIBILITIES

Home care clients have the right to be notified in writing of their rights and obligations before treatment is begun. The client's family or guardian may exercise the client's rights when the client has been judged incompetent. Home care providers have an obligation to protect and promote the rights of their clients, including the following rights.

YOU HAVE THE RIGHT TO:

- Be treated with dignity, courtesy and respect.
- Have relationships that are based on honesty and ethical standards of conduct.
- Reasonable coordination and continuity of services.
- Be fully informed upon admission of the company's policies, procedures, ownership or control of the local facility and the process for receiving, reviewing and resolving your complaints or concerns.
- Receive complete explanations of charges for services and equipment, including eligibility for third-party reimbursement and an explanation of all forms you are requested to sign.
- Participate in decisions concerning the nature and purpose of any technical procedure which will be performed and who will perform it, the possible alternatives and/or risks involved and your right to refuse all or part of the services and to be informed of expected consequences of any such action.
- Confidentiality of all your records (except as otherwise provided for by law or third-party payer contracts) and to review and even challenge those records and to have your records corrected for accuracy.
- Express dissatisfaction and to suggest changes in any service without discrimination, reprisal or unreasonable interruption of services.
- Accept or refuse medical treatment while competent and to make decisions about care/services to be received should you lose competency.

CLIENT RESPONSIBILITIES:

- Adhere to the plan of treatment or service established by their physician.
- Provide medical and personal information necessary to plan and provide services.
- Communicate any information, concerns and/or questions related to pain.
- Notify the company if he/she is going to be unavailable.
- Treat company personnel with respect and dignity without discrimination.
- Provide a safe environment for staff to provide care and services.
- Except where contrary to federal or state law, the client is responsible for charges which the client's insurance company or companies does not pay. The client is responsible for settlement in full of his/her accounts.
- The company should be notified of any changes in the client's physical condition, physician's prescription or insurance coverage. Notify the company immediately of any address or telephone changes whether temporary or permanent.

CLIENT INFORMATION:

- Complaint Procedure:
  - You have the right and responsibility to express concerns, dissatisfaction or make complaints about services you do or do not receive without fear of reprisal, discrimination or unreasonable interruption of services. The company telephone number is 855-238-4949. When you call, ask to speak with the Supervisor.
  - Advanced Laboratory Services has a formal grievance procedure that ensures that your concerns shall be reviewed and an investigation started within 48 hours. Every attempt shall be made to resolve all grievances within 14 days. You will be informed in writing of the resolution of the complaint/grievance.

I have been informed of and understand my rights and responsibilities.

Client Signature: _____ Date: _____

Company Representative: _____ Date: _____