ASSIGNMENT OF BENEFIT AND FINANCIAL POLICY

I authorize Carolina Internal Medicine Associates (CIMA) to file insurance on my behalf and request payment of authorized medical benefits for services provided to me are made directly to CIMA. I understand that if I do not have active coverage, in-network coverage, or choose not to utilize my insurance benefits, I am responsible for all charges incurred at time of service.

I authorize the release of medical and/or account information to my health insurance carrier that is necessary to process claims and/or to verify plan benefits in accordance with HIPAA health information standards.

Initials _______________

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to medical care and treatment, diagnostic radiology procedures, lab tests, and any other services deemed necessary by the healthcare providers treating me at any Carolina Internal Medicine Associates' facility.

I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE).

If I have provided my e-mail address, I am requesting the ability to access my medical information through the patient portal

If I have provided my home and/or cell phone number, I am requesting the ability to receive communications via phone or text including but not limited to automated appointment reminders and care gap notifications.

I have the right to opt out at any time of any form of electronic communication.

I have been informed and understand that CIMA providers using the electronic prescribing system will be able to see information about medications I am currently taking, including those prescribed by other providers. I give consent to my CIMA providers to see this health information.

I understand that CIMA participates in the North Carolina Department of Health's statewide immunization registry that collects vaccination history and information to serve

the public health goal of preventing the spread of vaccine preventable diseases. I do hereby grant permission for CIMA to send and receive immunization records.

Initials ____________

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I have been given the opportunity to read Carolina Internal Medicine Associates' Notice of Privacy Practices, and my questions concerning the notice have been answered.

I understand if I choose not to sign this acknowledgment, CIMA will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with CIMA's Notice of Privacy Practices.

Initials ___________

**Copy of full policies available upon request and can be found at https://carolinaim.com

Patient or authorized representative signature: ____ **Date:** __________