Oak St. Health

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

General Consent to Treat:
I hereby authorize medical evaluation, diagnosis, physical examination, laboratory testing, counseling, and treatment by Oak Street Health. I understand that I have the right to discuss with my practitioner any cultural, religious, spiritual, or other preferences that impact my visit or treatment plan. I further understand that I should notify my provider if I have any language or communication challenges.

Consent to Tele-Health Services: I understand that Oak Street Health may provide certain services by remote telehealth technology, including, but not limited to, tele-behavioral health. Such tele-behavioral health services involve a health provider who is at a site remote from my location at the time of the service, and, as such, often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription.

Financial Responsibility: I understand that I am responsible for any balance not paid by my insurance. This includes scenarios in which I am informed that the service I am seeking is not a contracted service with my insurance plan. In such scenarios, I acknowledge that I am required to pay for this service out-of-pocket at the close of the visit. I further acknowledge that if my insurer covers the cost of the service provided at today's visit, that I am responsible for paying the co-payment and/or deductible amounts at the time of service. I understand that my visit may require labs that will be processed by a third-party lab, and that additional charges may apply.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to Oak Street Health all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Oak Street Health's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third parties. I consent to any request for review or appeal by Oak Street Health to challenge a determination of benefits made by a third-party payer.

Use and Disclosure of Health Information: Oak Street Health may use or disclose your health information as set forth in the Notice of Privacy Practices, a copy of which has been made available to me at my request.

- ☐ I acknowledge that Oak Street Health may electronically share my health information with other providers for treatment, healthcare operations and payment purposes, as well as for care coordination as permitted by Federal and state laws.

Oak St. Health

Notice of Privacy Practices
Available here: https://www.oakstreethealth.com/hipaa-notice.

- ☐ I acknowledge that a copy of the Notice of Privacy Practices has been made available to me.

HIPAA Marketing Authorization

- ☐ I authorize Oak Street Health LLC and its subsidiaries and affiliated CVS Health companies to use my health information to send personalized marketing messages about new products, programs and services that I may be interested in, including those funded by third parties.

By opting in, I authorize Oak Street Health LLC and its subsidiaries and managed entities and affiliated CVS Health companies to use my information to send me information about programs and services that I may be interested in, including those funded by third parties. I understand that (1) my treatment, payment for treatment and eligibility for benefits at Oak Street Health does not depend on my signing this Authorization; (2) once used for marketing purposes, my information may no longer be subject to HIPAA, the federal law that regulates use and disclosure of protected health information or similar state laws; (3) this Authorization will be valid until I revoke it and that I have the right to cancel this Authorization at any time by calling 888–776-4854, but that my cancellation will not apply to any action that Oak Street Health has already taken based on this Authorization before revocation; and (4) I am entitled to a copy of this Authorization.

Telephone Consumer Protection Act

- ☐ I agree to receive automated or pre-recorded calls and/or texts from or on behalf of Oak Street Health about my healthcare, my appointments, and marketing. Consent is optional and not a condition for purchasing. See Oak Street Health's Telephone, Text, and Fax Terms and Conditions here: https://www.oakstreethealth.com/messaging-agreement.Text STOP to opt out at any time. Message frequency varies. Data rates may apply.

BY SIGNING BELOW, I AM INDICATING THAT I HAVE REVIEWED AND ACKNOWLEDGE AND CONSENT TO THE ABOVE.

_____	_____
Signature of Patient or Responsible Party	Date
_____	_____
Printed Name of Patient or Responsible Party	Responsible Party Relationship to Patient
_____	_____
Service Location	Phone Number
_____	_____
Address	City State Zip