



# RISK MANAGEMENT

Carolyn Todd Mahon, PhD, MSN, MBA

Medical Business Institute

Dallas, Texas

# RISK MANAGEMENT

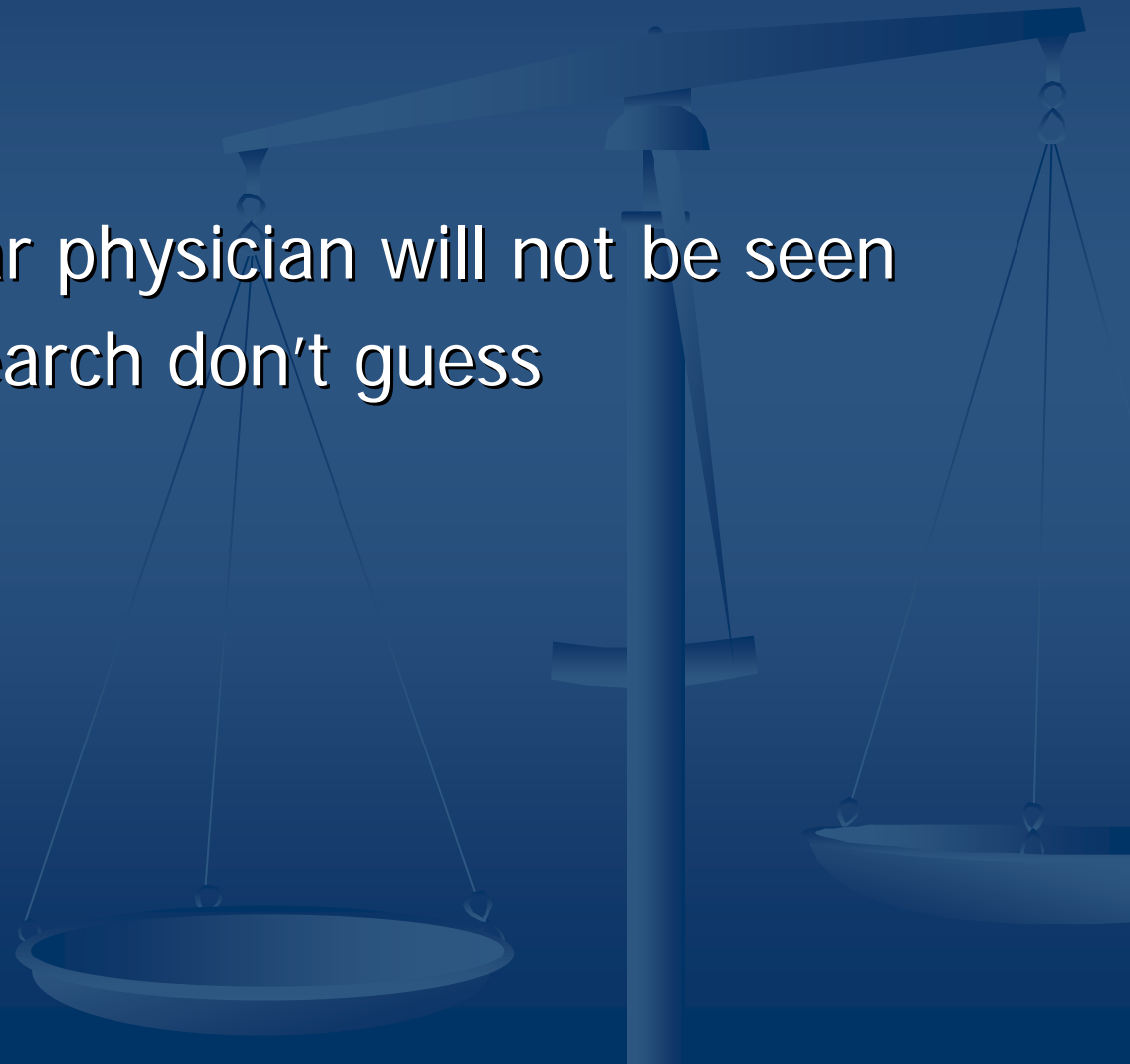


## ■ INTRODUCTION:

- Increase the defensibility of your plastics practice
- MBI reviews three key issues regarding loss prevention
  - Patient relations
  - Office procedures
  - Medical records

# RISK MANAGEMENT

- Perceptions
  - No guarantees
  - Inform if regular physician will not be seen
  - Questions: research don't guess



# RISK MANAGEMENT

## ■ PATIENT RELATIONS

### ■ PATIENT EDUCATION

- MEDICAL OFFICE IS NOT CONDUCIVE TO LEARNING
- AVOID THE WORDS "DO YOU UNDERSTAND?"
- ASK QUESTIONS DO NOT PROVIDE ANSWERS
- MEDICAL JARGON
- BE SPECIFIC-MAKE SURE THE PATIENT UNDERSTANDS
- CERTAIN WORDS IMPACT
- WRITTEN INSTRUCTIONS ARE BEST
  - NOTE IN CHART THAT INSTRUCTIONS WERE GIVEN

# RISK MANAGEMENT



- PATIENT RELATIONS
  - CONFIDENTIALITY/HIPAA PRIVACY REGS
    - IMPLIED CONSENT
    - MINIMUM NECESSARY
    - SIGN IN SHEETS
    - QUESTIONS IN RECEPTION AREA
    - THIRD PARTY IN EXAM ROOM PERMISSION

# RISK MANAGEMENT

## ■ OFFICE PROCEDURES

- YOU MUST KEEP THE SCHEDULED TIME TOO
- APPOINTMENT SCHEDULING/FOLLOW-UP
  - APPOINTMENT SCRIPT
  - REMINDER CARD exhibit B
  - APPOINTMENT REMINDER CALL
  - CALL AFTER MISSED APPOINTMENT/exhibit C
  - DOCUMENT MISSED APPOINTMENTS
  - DOCUMENT EFFORTS TO CONTACT
    - SHOWS GOOD FAITH EFFORT TO INFORM

# RISK MANAGEMENT



## ■ OFFICE PROCEDURES

### ■ TESTS RESULTS

- KEEP LOG OF TESTS DONE
- INSURE ALL TEST REQUESTED HAVE BEEN RECEIVED
- WHEN REPORTS RECEIVED CHART PULLED AND TESTS RECORDED AND REVIEWED
- REVIEW IS RECORDED IN CHART AND SIGNATURE ON REPORT AND/OR PROGRESS NOTE
- RESULTS COMMUNICATED TO PATIENT WITH DOCUMENTATION TO THAT EFFECT
- NO RESULTS LEFT ON VOICE MAIL/ANSWERING MACHINE

# RISK MANAGEMENT



- OFFICE PROCEDURES
  - MEDICATION CONTROLS
    - CONTROL PRESCRIPTION PADS
    - MEDICATION SHEET IN EACH PATIENT CHART
    - TRACK PRESCRIBED AND REFILLED
      - DATE, DOSAGE, AND INSTRUCTIONS
      - INITIAL MEDICATION SHEET WITH EACH ADDITION
    - BRING ALL MEDICATIONS ON FIRST VISIT
      - AVOID DRUG INTERACTIONS
    - DOCUMENT ALL ALLERGIES/ADVERSE REACTIONS
      - ASK ABOUT ALLERGIES BEFORE EACH ADMINISTRATION
      - DOCUMENT ALLERGIES
    - SAMPLES LOG EXHIBIT V
      - TREAT SAMPLES AS DRUGS PRESCRIBED AND FILLED
      - LOG IN WHEN RECEIVED WITH LOT AND EXPIRATION
      - LOG OUT WHEN DISPENSED
      - PURGE OUT OF DATE DRUGS

# RISK MANAGEMENT



- OFFICE PROCEDURES

- MEDICAL EMERGENCIES

- IF CRASH CART IS KEPT:

- PERSONNEL CERTIFIED

- SUPPLIES CHECKED AND LOGGED

- WHEN PHYSICIAN IS PRESENT

- DEVELOP WRITTEN PROTOCOL

- WHEN PHYSICIAN IS NOT PRESENT

- SEND TO ER

- DIAL 911

# RISK MANAGEMENT

## ■ MEDICAL RECORDS

- FINANCIAL PERSONAL LEFT/CLINICAL RIGHT
- ORIGINAL DOCUMENTS ONLY (NON- ORIGINAL OBJECTIVE ONLY)
- ADEQUATE MEDICAL HISTORY
- ALLERGY STICKERS ON OUTSIDE FOR ALLERGIES ONLY
- PATIENT NAME ON EACH PAGE
- DOCUMENT OTHER THAN TREATMENT
  - PHONE CALLS
  - MISSED APPOINTMENTS
  - FAILURE TO FOLLOW ADVICE/INSTRUCTIONS
  - MEDICATION REFILLS
  - INSTRUCTIONS TO PATIENT AND/OR FAMILY
  - VERBAL INSTRUCTIONS
  - PATIENT EXPRESSED UNDERSTANDING
  - RECORDS RELEASED
    - TO WHOM
    - WHEN
    - PROPER RELEASE/AUTHORIZATION

# RISK MANAGEMENT



- DOCUMENTATION TIPS
  - STATE FACTS
    - OBJECTIVE NOT SUBJECTIVE
  - AVOID PERSONAL ABBREVIATIONS
    - STANDARD AND ACCEPTED ABBREVIATIONS
  - BLACK INK PHOTOCOPIES
  - NO BLANK SPACES
  - SIGN AND DATE EACH ENTRY
  - DATE AND PATIENT NAME AT TOP OF EVERY PAGE
  - DOCUMENT ALL CONTACT WITH PATIENT
    - Phone conversations
  - DOCUMENT ALL INSTRUCTIONS TO PATIENT/FAMILY
    - Prescription directions understood
  - INITIAL ALL REPORTS BEFORE THEY ARE PART OF RECORD
  - NO NOTES THAT SAY DICTATED BUT NOT READ IN RECORD
  - NEVER OBLITERATE AN ENTRY/ LINE THROUGH AND INITIAL

# RISK MANAGEMENT

## ■ MEDICAL RECORDS

### ■ RELEASE OF MEDICAL RECORDS

- ORAL RELEASE FOR EMERGENCY ONLY
- INFORMATION BELONGS TO PATIENT
- RELEASE MUST HAVE HIPAA COMPLIANT FORM
  - EXHIBIT F
- WAIVER FOR FAXED RECORDS
  - EXHIBIT I
- RELEASE COPIES NEVER ORIGINAL
- NEVER RELEASE RECORDS FROM OTHER PROVIDERS

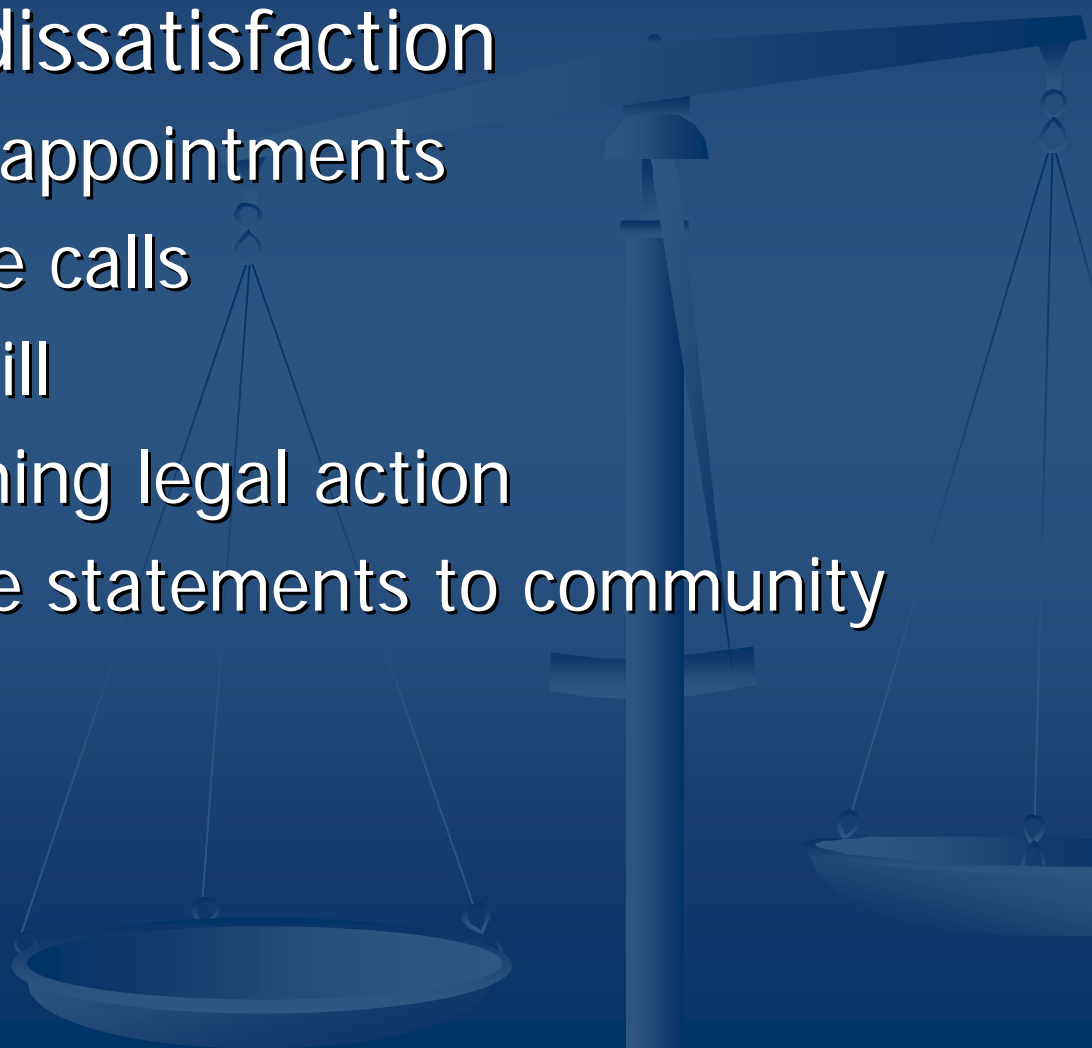
# RISK MANAGEMENT

- **Patient Education** Did the medical record contain evidence of first-visit patient education and discussion of the procedure to be performed?
- **Informed-consent Documentation**—Was the informed-consent process adequate, with sufficient documentation to protect the physician?
- **Smoker**—If the patient was a smoker, does the medical record reflect advising the patient of the detrimental effects of smoking on scarring and healing?
- **History and Physical Examination**—Were a complete physical examination and assessment of the patient performed? Did the history and physical examination include a complete medical history, *especially as related to surgery, anesthesia, and allergies?*

# RISK MANAGEMENT

- **Facility**—If it was an outpatient procedure, was the facility appropriate?
- **Operating Time**—Was surgical operating time appropriate for an outpatient setting?
- **Recovery and Monitoring**—What was the status of ancillary personnel who remained with the patient during the recovery period?
- **Dictation**—Does the surgical dictation match the operation? Was it dictated late? Was it appropriate for what was performed?
- **Discharge**—Was the patient discharged home? If not, where was the patient sent?

# RISK MANAGEMENT

- Expressions of dissatisfaction
    - Failure to keep appointments
    - Angry telephone calls
    - Failure to pay bill
    - Letters threatening legal action
    - Making negative statements to community
- 

# RISK MANAGEMENT

## ■ FEES

- COLLECTING FEES IS A VOLATILE AREA
  - EDUCATE PATIENTS TO YOUR POLICIES
  - PUBLISH POLICIES WITH SIGNAGE
  - NO SUPRISES
- DISCUSS FINANCIAL OBLIGATIONS PRIOR TO SERVICE (SEE EXHIBIT M-P)
- IN PRIVATE
- USE A FORM THAT PATIENT SIGNS ACKNOWLEDGING DISCUSSION
- NOTIFY IN ADVANCE OF INTEREST OR OTHER ADDED CHARGES

# RISK MANAGEMENT



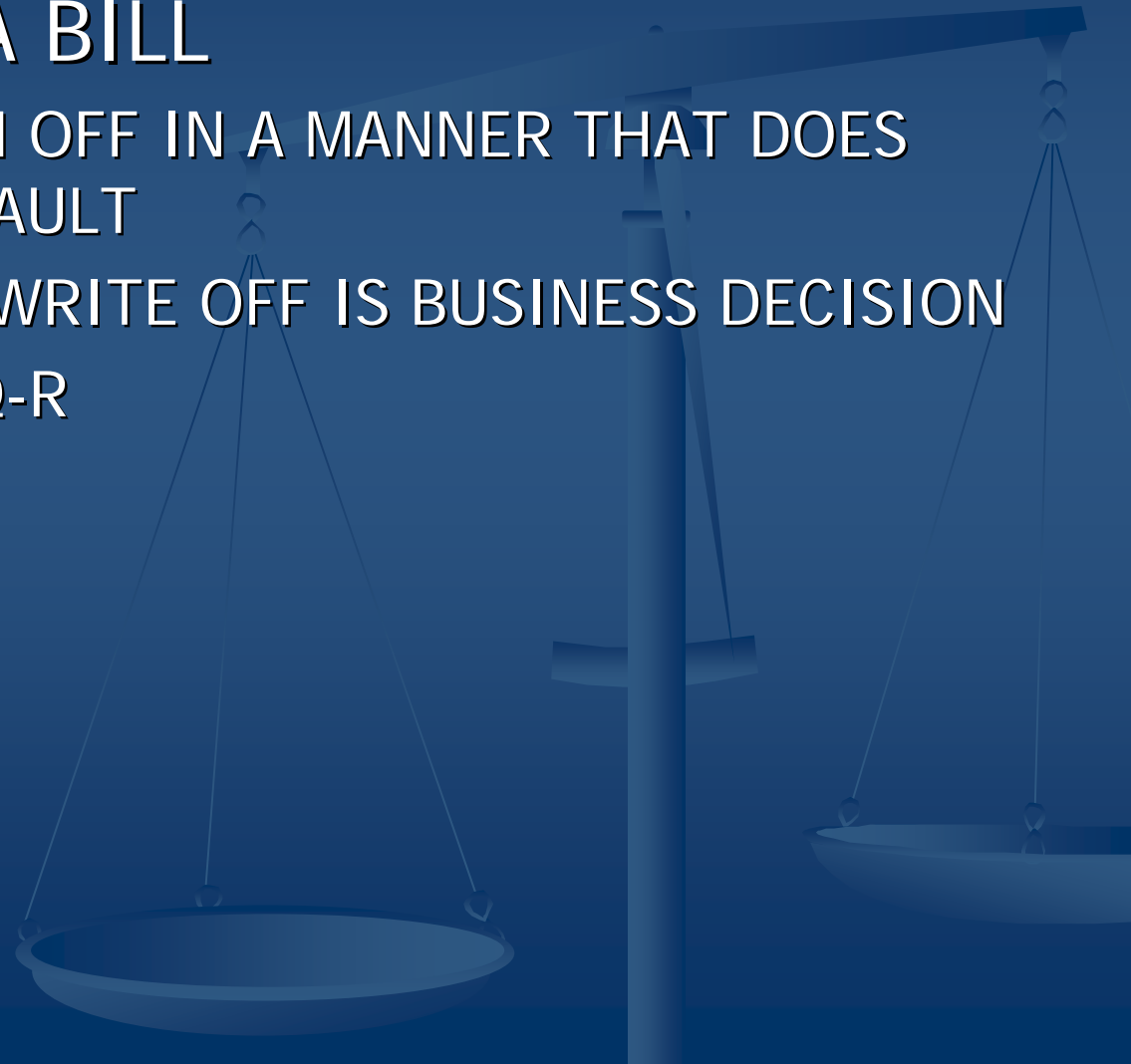
- INSURANCE IS STICKY ISSUE
- WHEN OR NOT TO SEND TO COLLECTIONS
  - REASON FOR FAILURE TO PAY
  - DON'T ASSUME IRREGULAR PAYMENTS MEAN UNWILLING TO PAY
  - PROCEDURE TO WORK WITH FINANCIAL DIFFICULTIES OF PATIENTS

# RISK MANAGEMENT

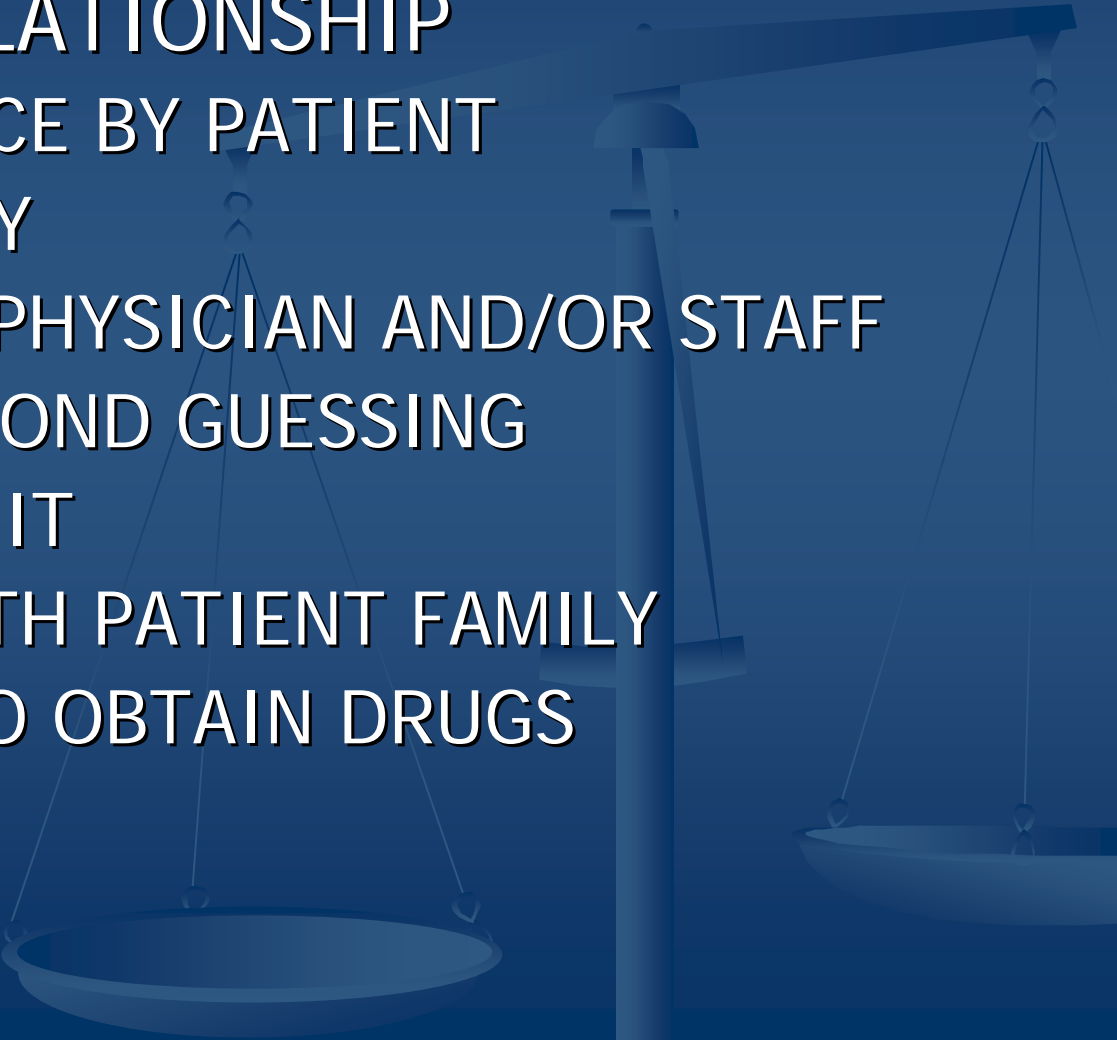
- BEFORE TURNING OVER TO COLLECTION
  - PHYSICIAN REVIEW PATIENT CHART
  - DR ONLY APPROVAL FOR AGGRESSIVE COLLECTION
  - MONITOR AGENCY'S ACTIVITIES
  - LITIGATION ONLY WITH DR REVIEW
  - NOTIFY DR IF PATIENT QUESTIONS FEES
  - SPECIAL ARRANGMENTS FOR HARDSHIP

# RISK MANAGEMENT

- WRITING OFF A BILL
  - FEES WRITTEN OFF IN A MANNER THAT DOES NOT ADMIT FAULT
  - DECISION TO WRITE OFF IS BUSINESS DECISION
  - SEE EXHIBIT Q-R



# RISK MANAGEMENT

- TERMINATE RELATIONSHIP
    - NONCOMPLIANCE BY PATIENT
    - FAILURE TO PAY
    - HOSTILITY TO PHYSICIAN AND/OR STAFF
    - CONSTANT SECOND GUESSING
    - FILED A LAWSUIT
    - CONFLICTS WITH PATIENT FAMILY
    - VISITS ONLY TO OBTAIN DRUGS
    - EXHIBITS S-T
- 

# RISK MANAGEMENT



- HOW LIKELY ARE YOU TO BE SUED?
  - THE BASICS
    - CONSIDER: HOW WELL DO YOU UNDERSTAND THE LEGAL CONCEPTS OF NEGLIGENCE, DUTY, AND CASUAL CONNECTION? HAVE YOU COMPARED YOURSELF WITH OTHER PHYSICIANS WHO HAVE SIMILAR TRAINING TO MAKE SURE THAT YOU ARE EXERCISING REASONABLE CARE DURING DIAGNOSTIC AND TREATMENT PROCEDURES?

# RISK MANAGEMENT

- INFORMED CONSENT AND FOLLOW-UP
  - CONSIDER: DO YOU FULLY EXPLAIN TO YOUR PATIENTS THE RISKS OF MEDICATIONS PRESCRIBED AND PROCEDURES TO BE PERFORMED, AND DO YOU TELL THEM ABOUT POSSIBLE ALTERNATIVES? DO YOU OBTAIN AND FILE THE SIGNED INFORMED CONSENT FORMS? DO YOU FULLY EXPLAIN FOLLOW-UP CARE, PRESCRIPTION INSTRUCTIONS AND GIVE WRITTEN INSTRUCTIONS IN LAYMEN'S LANGUAGE? IF A PATIENT DENIES DRUG ALLERGIES DO YOU ALWAYS NOTE "PATIENT STATES NKDA" ON THE CHART?

# RISK MANAGEMENT

## ■ RECORDKEEPING

- CONSIDER: HAVE YOU TRAINED YOUR STAFF TO KEEP METICULOUS RECORDS? DO YOU ALLOW YOURSELF ENOUGH TIME TO REVIEW RECORDS? HOW WELL ORGANIZED AND SYSTEMATIC IS YOUR CHARTING? IS YOUR HANDWRITING LEGIBLE TO OTHERS? DO YOU MAKE YOUR ENTRIES PROMPTLY WHILE YOUR MEMORY IS STILL FRESH? DO YOU SIGN AND DATE ALL REPORTS UPON REVIEW? DO YOU REVIEW, CORRECT, DATE AND SIGN ALL TRANSCRIBED RECORDS BEFORE THEY BECOME A PERMANENT PART OF THE CHART? DO YOU CHART SAMPLES AS IF THEY WERE PRESCRIPTIONS? DO YOU KEEP THE PATIENT'S MEDS LIST AND THE OFFICE SAMPLE LOG UP TO DATE?

# RISK MANAGEMENT

- RELATIONSHIP WITH PATIENTS
  - CONSIDER: DO YOU SPEND ADEQUATE TIME TALKING TO YOUR PATIENTS IN THE OFFICE? ARE YOU AND YOUR STAFF ACCESSIBLE TO YOUR PATIENTS? ARE YOU AND YOUR STAFF PLEASANT AND FRIENDLY? DO YOU RESPECT YOUR PATIENT'S TIME? DO YOU HAVE A STOOL FOR YOU TO SIT ON IN EVERY EXAM ROOM?

# RISK MANAGEMENT

- REGARD FOR PATIENTS' FINANCIAL NEEDS
  - CONSIDER: DO YOU EDUCATE YOUR PATIENTS ON YOUR FEES? DO YOU HAVE ADEQUATE SIGNAGE REGARDING PAYMENT OF FEES? DOES YOUR STAFF HANDLE INSURANCE FILING AND OTHER CLAIM MATTERS QUICKLY AND EFFICIENTLY? DOES YOUR STAFF CALL AND DISCUSS LATE PAYMENTS AND TRY TO ARRANGE REASONABLE SOLUTIONS? IS ALL THIS DONE WITH REGARD TO PRIVACY?

# RISK MANAGEMENT

## ■ ABANDONMENT

- CONSIDER: IF FURTHER PROCEDURES ARE NOT WARRANTED OR IF POST OP IS COMING TO AN END DO YOU TAKE THE TIME TO EXPLAIN THE SITUATION COMPLETELY TO THE PATIENT? IF YOU TERMINATE A RELATIONSHIP DO YOU DO SO IN WRITING AND GIVE THE PATIENT A TIME LINE FOR FINDING ANOTHER PROVIDER? RESCHEDULING DOES NOT CONSTITUTE ABANDONMENT!

# RISK MANAGEMENT

## ■ AVAILABILITY

- CONSIDER: ARE YOU AVAILABLE TO SEE PATIENTS ON SHORT NOTICE? IF YOU ARE UNAVAILABLE TO YOUR PATIENTS DO YOU ARRANGE FOR ADEQUATE COVERAGE? DO YOU HAVE A WRITTEN POLICY TO ACCOMMODATE EMERGENCIES?

# RISK MANAGEMENT

## ■ CAREFUL PRESCRIBING

- CONSIDER: ARE YOU ABLE TO FIND INFORMATION QUICKLY IN A PATIENT'S CHART REGARDING ALLERGIES, SMOKING HISTORY OR ADVERSE REACTIONS? DO YOU ASK PATIENTS ABOUT OTHER MEDICATIONS THEY MAY BE TAKING? DO YOU AND YOUR STAFF MAKE THOROUGH NOTES ABOUT PRESCRIPTIONS, REFILLS, SAMPLES GIVEN IN PATIENTS' CHARTS? DO YOU REVIEW AND INITIAL CHARTS WHEN YOUR NURSE MAKES ENTRIES REGARDING PRESCRIPTIONS? DO YOU ALWAYS EXPLAIN SIDE EFFECTS, RISKS AND HOW TO PROCEED SHOULD THOSE OCCUR? DO YOU GIVE WRITTEN INSTRUCTIONS? DO YOU KEEP PATIENT MEDS LISTS UP TO DATE?

# RISK MANAGEMENT

## ■ REFERRALS

- CONSIDER: DO YOU INFORM YOUR PATIENTS WHEN THEIR PROBLEMS ARE BEYOND YOUR EXPERTISE, AND DO YOU REFER THEM TO AN APPROPRIATE SPECIALIST? DO YOU MAKE A COMPLETE NOTE ABOUT THE REFERRAL IN THE PATIENT CHART? DO YOU PROVIDE COMPLETE AND ACCURATE INFORMATION TO THE SPECIALIST AND DO YOU CONFIRM RECEIPT OF PATIENT RECORDS OR OTHER INFORMATION YOU SEND OUT?

# RISK MANAGEMENT

- IN THE HOSPITAL

- CONSIDER: ARE YOU COMPLETELY CONFIDENT ABOUT THE EQUIPMENT, FACILITIES, AND STAFF OF THE HOSPITALS TO WHICH YOU ADMIT PATIENTS? DO YOU REVIEW THE PATIENT'S HOSPITAL CHART REGULARLY? DO YOU DISCHARGE PATIENTS YOURSELF? DO YOU THOROUGHLY EXPLAIN INSTRUCTIONS FOR THE PATIENT'S POST DISCHARGE CARE?

# MISC THOUGHTS

- Develop and apply proper patient-selection criteria; not everyone is a candidate for the surgery sought.
- Develop and apply facility-selection criteria. Determine the appropriate facility (hospital or outpatient) by rating the anticipated length of the procedure against the patient's present condition.
- Develop or purchase and use up-to-date patient education literature on the procedure to be performed. Assess the patient's level of understanding of the materials and the procedure, and address the patient accordingly.
- Develop a uniform surgical informed-consent process to be utilized in the facility.
  - Condense the informed-consent document to one page if possible; research shows that one page is the full extent of the average patient's understanding and retention.
  - If additional information is necessary for patient education (i.e., smoking), prepare a special disclosure documenting the physician's discussion with the patient.
- Develop a separate anesthesia informed-consent document and process. A single sentence related to anesthesia buried in the surgical consent form may not offer the anesthesiologist adequate coverage if an adverse anesthesia-related event occurs.
- Perform a full and complete physical examination, using the patient health questionnaire; review lab work.
  - Ask about scars that are not included in the patient's history, and follow up on any positive response; consider referring the patient elsewhere for surgical clearance.
  - Pay attention to the patient's medical history. If there were prior surgeries, ask about and record any anesthesia reactions.
- Always ask about and document medication allergies.
- Develop standard-of-care protocols for the recovery phase.
  - A physician must remain in the facility and be readily available during the full recovery period, until the last patient is discharged.
  - If a CRNA administers the anesthesia, the surgeon should remain available.
  - Anytime a patient is placed under anesthesia, someone with advanced life support training should be on-site.
- Develop and apply facility standards for patient discharge.
- Provide complete patient information for transfer to a receiving facility when transfer is necessary.
- Develop and use a postoperative follow-up telephone call routine when patients are discharged home.
- Preoperatively, determine if the patient can go home or will need professional care for the first night. If professional care is required, arrange for hospital admission, a visiting nurse, or home health care.
- Be sure of all of your coworkers' credentials.
  - Confirm licensure and insurance coverage.
  - Review state regulations that pertain to outpatient facilities, and limit yourself to those that meet the standards.
- Maintain a complete, legible medical record.
- Although these recommendations are not guaranteed to keep you litigation-free, they will help a great deal to make any claim against you more defensible.

# EXHIBIT A

## TELEPHONE NOTE PAD

CONFIDENTIAL PATIENT INFORMATION

PATIENT MANAGEMENT PHONE PAD

DATE \_\_\_\_\_ TIME \_\_\_\_\_ a.m. p.m DOCTOR \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ FILE # \_\_\_\_\_

PATIENT'S HOME ADDRESS \_\_\_\_\_

PATIENT'S HOME PHONE # \_\_\_\_\_

PATIENT'S COMPLAINT \_\_\_\_\_

TREATMENT RECOMMENDED \_\_\_\_\_

MEDICATIONS PRESCRIBED \_\_\_\_\_

TESTS ORDERED \_\_\_\_\_

SPECIAL INSTRUCTIONS OR NOTES \_\_\_\_\_

MESSAGE TAKEN BY \_\_\_\_\_

# EXHIBIT B

## FOLLOW-UP REMINDER CARD

Dear (name of patient):

According to our records, it is time for your (six month) follow-up appointment. In order for us to provide continuity of care, it is very important you call at your earliest convenience to set up an appointment.

Our office hours are from (time).

Telephone number is (phone #).

(Signature)

# EXHIBIT C

## MISSED OR CANCELED APPOINTMENTS

Dear (name of patient):

According to our records, you have failed to keep your scheduled appointment. In order for us to provide continuity of care, it is very important you keep all scheduled appointments. As a reminder we may charge \$\_\_\_\_\_ for appointments not cancelled within 24 hours of the appointment time.

Please contact this office at your earliest convenience to reschedule your appointment.

Our office hours are from (time).

Telephone number is (phone #).

(Signature)

# EXHIBIT E

## GENERAL AUTHORIZATION MEDICAL INFORMATION AUTHORIZATION

TO: \_\_\_\_\_ (Name of Physician)

RE: \_\_\_\_\_ (Name of Patient)

You are hereby authorized to furnish \_\_\_\_\_ (NAME) any or all medical information concerning my injuries, disabilities, and physical condition, including all medical records and x-rays covering the period from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_. You are directed and authorized to furnish complete medical reports on my medical history, past, present, and future, and to permit \_\_\_\_\_ (NAME) to view, copy, or obtain photocopies, or other such reproductions of any medical record in your possession covering the above period. A photo static copy of this authorization shall be considered as valid as the original.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

- Not Valid if Presented More than 90 Day
- From Date of Authorization
- Not Valid if Dated Prior to Period of Treatment
- Not to be used to release drug & alcohol or psychiatric treatment record



# EXHIBIT G

## REQUEST FOR MEDICAL & OTHER INFORMATION

DATE: \_\_\_\_\_

RE: \_\_\_\_\_

HISTORY #:/D.O.B.: \_\_\_\_\_

This is a multiple action form letter with only those items indicated by an "X" being applicable.

### IN ANSWER TO YOUR REQUEST FOR MEDICAL INFORMATION

Please see attached medical record copies. NOTE: Request for copies of the entire record will include only the last 2 years of lab work. The attached medical information is CONFIDENTIAL. Subsequent disclosure is not authorized without the specific consent of the patient.

### REQUEST FOR ADDITIONAL INFORMATION

Your request is being returned for the following reasons:

The authorization is not HIPAA compliant

We are unable to locate a record of treatment for this individual. Please provide additional information, such name of patient at time of treatment, date of birth, history #, or verification of spelling of name.

### RETURN YOUR REQUEST WITH THE INFORMATION.

No record on file for specified dates.

Medical information is confidential and can be released only on written authorization of patient/patient's legally authorized representative.

### HAVE THE PATIENT COMPLETE THE ENCLOSED AUTHORIZATION AND RETURN WITH YOUR REQUEST.

Authorization date has expired.

### RETURN YOUR REQUEST WITH A MORE RECENTLY DATED AUTHORIZATION SIGNED BY THE PATIENT/PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE.

Our charge for releasing records directly to the patient/patient's representative is \$\_\_\_\_\_. If you provide us with the name and address of your new physician, we will send the copies instead, thereby eliminating the charge. Otherwise, make check payable to \_\_\_\_\_, put patient's name on the check, and return a copy of this letter with check.

Please remit \_\_\_\_\_, which is our fee for processing your request and photocopying the requested record. Make check payable to \_\_\_\_\_, reference the patient's name on the check, and return a copy of this letter with check.

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# EXHIBIT H

## SPECIAL AUTHORIZATION

### AUTHORIZATION OF MEDICAL RECORDS INCLUDING RECORDS RELATING TO DRUG OR ALCOHOL TREATMENT & PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT OR AIDS AND HIV STATUS

TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The undersigned hereby authorizes you to discuss with, disclose or prepare and furnish a report of the medical condition or conditions of \_\_\_\_\_, including any condition or care related to drug and/or alcohol dependency, psychiatric or psychological diagnosis, or HIV or AIDS status to any member of employee of \_\_\_\_\_, and also to permit such person or persons to examine and copy any documents, records, pictures or x-rays, under your control for the purpose of \_\_\_\_\_. Any expenses involved in reporting, discussion or reproduction will be paid by \_\_\_\_\_.

It is acknowledged that this consent is subject to revocation at any time except to the extent the person whom is to make the disclosure has already acted in reliance upon it. This consent will expire 90 days from the date of signature unless previously revoked. Further, it is understood that the records disclosed pursuant to this consent may not be redisclosed without the specific written consent of the patient.

A COPY OR PHOTOCOPY OF THIS AUTHORIZATION WILL SERVE THE SAME VALIDITY AS THOUGH AN ORIGINAL HAD BEEN PRESENTED.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed:

### ACKNOWLEDGMENT

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

On this \_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me a Notary Public, in and for the county and state aforesaid, came \_\_\_\_\_, personally known to me to be the same person who executed the above instrument and duly acknowledged the execution of same.

IN WITNESS THEREOF, I have hereunto set my hand and seal on the date last above written.

(SEAL)

\_\_\_\_\_  
Notary Public

My Appointment Expires: \_\_\_\_\_

# EXHIBIT I

## MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION

I, \_\_\_\_\_, understand that you will be transmitting my medical records electronically and authorize you to do so. If they are received by another party in error, I absolve Dr. \_\_\_\_\_ of any and all liability relating to such transmission of said records.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# EXHIBIT K

## LETTER TO BE USED TO WRITE OFF FEES

Dear Patient:

I am writing in response to your request that I write off my fees associated with your treatment of \_\_\_\_\_ (date) \_\_\_\_\_. As we discussed prior to treatment, \_\_\_\_\_ is a known complication. While it is unfortunate that these problems occurred, the fact that they did is not an indication that my treatment was inappropriate. In spite of the complications, I feel very strongly that my treatment was proper, however, I also understand the frustration you are feeling over the medical bills that have resulted. Accordingly, I am willing to honor your request that these charges be taken off of your bill.

Sincerely,

# EXHIBIT L

## RELEASE OF ALL CLAIMS

The undersigned \_\_\_\_\_ (Claimant/Patient \_\_\_\_\_), in consideration of (Dr. X's agreement to write off all of my bill or \$(dollar amount) of my bill) hereby releases (Dr. and/or P.A.) from any and all claims and causes of action of every kind whatsoever that now exist or hereafter may arise from Dr. \_\_\_\_\_ X's treatment of \_\_\_\_\_ (Patient) \_\_\_\_\_ in \_\_\_\_\_ (Month) \_\_\_\_\_ of 2007.

This release shall apply to all claims, actions, demands, loss of services, costs, losses, damages, expenses and causes of action of every kind which now have or may hereafter accrue, arise on account of or in any way growing out of directly or inconsequentially from the incident described above.

The parties released in addition to those named above, shall include all of their agents, servants, successors, heirs, executors, administrators, and all other persons, firms, corporations, associations or partnerships. This release is a result of Dr. \_\_\_\_\_ X's agreement to waive certain parts of his fee and shall never at any time be considered an admission of liability or responsibility on the part of the parties herein released and such parties deny any liability and disclaim any such responsibility.

It is understood and agreed that this instrument may be pleaded as a defense in bar or abatement of any action or kind whatsoever brought, instituted or taken on behalf of \_\_\_\_\_ (Patient) \_\_\_\_\_ on account of such treatment by Dr. \_\_\_\_\_ X \_\_\_\_\_.

The above sum is the entire and only consideration for this release and the parties shall be responsible for any other expenses occurred as a result of the above described incident.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 2007.

\_\_\_\_\_  
(Claimant/Patient)

### ACKNOWLEDGMENT

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

BE IT REMEMBERED, that on this \_\_\_\_\_ day of \_\_\_\_\_, 2003, before me, the undersigned, a Notary Public in and for the county and state aforesaid, came \_\_\_\_\_ (Claimant/Patient \_\_\_\_\_), who is personally known to me to be the same person who signed the above document and said person duly acknowledged the execution of the same and swore to the same in my presence.

My appointment expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

# EXHIBIT M

## LETTER LIMITING PHYSICIAN PATIENT RELATIONSHIP

(Date)

I understand that I am being seen as a follow up to my recent emergency room visit as assigned by the hospital. I understand that since I have made contact with your office within 48 hours of my emergency room care on \_\_\_\_\_, I will be able to see the physician through my acute illness. I understand I will not be able to continue medical care through this office after that time.

However, I have been advised to contact "Ask-A-Nurse" or my local county medical society to find a physician who would be available for routine medical care.

---

Patient Name Printed

---

Patient Signature

---

Date

# EXHIBIT T

(Date)

Dear (Patient):

Due to failure to establish and maintain a satisfactory physician patient relationship we find it necessary to withdraw from your care. We will be glad to provide limited emergency care only for the next 30 days. We recommend you call "Ask-A-Nurse" or your local county medical society to find a physician who would be available for your medical care.

Sincerely,

**Certified Mail**