Injury Care Associates

www.injurycareco.com

Patient Name: _____ Date: _____

Consent to Treatment or Evaluation

I voluntarily request and consent to medical services from Transcend Medical LLC dba Injury Care Associates including its affiliated practices, employees, and other service providers (together, "Injury Care Associates"). I consent to procedures and ancillary services that may be performed by clinic employees under the general or specific instruction of my physician or the physician's designees. I understand that no guarantees have been made about the results of my treatment or services.

I confirm that the information I give Injury Care Associates is accurate and current to the best of my knowledge, and I agree to tell staff promptly if anything changes.

If my visit is an evaluation or test requested by my employer or a prospective employer (such as a fitness-for-duty exam, pre-placement exam, or drug or alcohol test), I understand that the service is performed at my employer's request and there is no treating provider relationship established as a result of the visit. I understand that results will be reported to the requesting employer.

Signature of Patient or Representative: _____

Acknowledgment of Notice of Privacy Practices

I received a copy of the Injury Care Associates HIPAA Notice of Privacy Practices. I understand it describes how my health information may be used and disclosed and explains my rights, and that the current notice is also posted in the clinic, available on request, and available at www.injurycareco.com.

Signing is an acknowledgment of receipt and is not a condition of treatment.

Signature of Patient or Representative: _____

Workers' Compensation – Acknowledgment of Information Sharing

I understand that for my work-related injury, illness, or exposure, Colorado workers' compensation law authorizes or requires Injury Care Associates to communicate with my employer, the insurer or claims administrator, and others involved in my claim. I understand that Injury Care Associates may share medical information with my employer that is related to the work incident and pertinent to my claim, which may include my diagnosis for the work-related condition, my treatment plan, expected outcome and timeline of treatment, my work status and restrictions, and claim status information. I understand that Injury Care Associates does not share information about conditions unrelated to my work injury, illness, or exposure, or other information not pertinent to my claim. These communications are described in more detail in the Notice of Privacy Practices.

Signature of Patient or Representative: _____

Financial Responsibility

I understand that workers' compensation is a state-regulated system for work-related injuries and illnesses, and that whether my claim is accepted is decided by the insurer or claims administrator, or by a judge if the decision is disputed.

If my claim is accepted. If my claim is accepted as compensable, or is ordered compensable by a judge, Injury Care Associates will bill the insurer, claims administrator, or employer for authorized, reasonable, and necessary treatment of my work-related condition, and as Colorado law requires, will not bill me for that treatment.

If my claim is denied or determined to be non-compensable. I understand that if my workers' compensation claim is denied, or if it is determined that my condition is not compensable under workers' compensation, and payment is denied on that basis, **I am financially responsible for the cost of the services I received.** In that case Injury Care Associates may bill me or my health insurance for those services. I understand that this applies to services received before the denial or determination as well as after it.

If my claim status changes. If a denied claim is later accepted or ordered compensable, Injury Care Associates will bill the workers' compensation payer for covered services and will refund or adjust any amounts I paid for those services as required by law.

I understand that nothing in this section waives my right to dispute a denial or to pursue my claim.

I agree to tell Injury Care Associates promptly of any change that may affect my claim or payment, such as a change in claim status, denial of coverage, change in insurer, claim settlement, address or phone number, or treating provider. I agree that a photocopy of this form is as valid as the original.

Signature of Patient or Representative: _____

Billing and Payer Communications

I authorize Injury Care Associates to bill the workers' compensation insurer, claims administrator, or employer for services related to my claim, and my employer or its designee for employer-directed services. I understand that Injury Care Associates will provide the insurer, claims administrator, employer, or other payer the information needed to process and pay claims, to verify that services were authorized and medically necessary, and to respond to audits and utilization review, limited to the minimum necessary for those purposes except where the law requires or allows more.

Signature of Patient or Representative: _____

Appointment Policy

I understand that I am expected to provide at least 24 hours' notice if I cannot attend a scheduled appointment. I understand that the workers' compensation insurer or claims administrator, and my employer, may be informed of canceled, rescheduled, or missed appointments as part of my claim. I understand that not following the treatment schedule set by my medical team may lengthen my recovery and affect my treatment outcome. Non-compliance with the recommend treatment schedule may result in a discharge or transfer of care.

Signature of Patient or Representative: _____

Notice of Technology and Recordings

We use technology tools, including artificial intelligence (AI), to support documentation, searching our systems, and to support administrative workflows. These tools are used under agreements that require vendors to protect your information. Your provider remains responsible for your care and reviews your medical records. We may take photographs or make audio or video recordings for clinical purposes only. We do not use them for marketing or other non-clinical purposes without your written authorization. You may ask us not to use AI scribe recording during your visit.

Signature of Patient or Representative: _____