QRS QUALITY REIMBURSEMENT SERVICES Healthcare Consultants

12/16/2015

lilatest

,

Hello,

I recently talked to you about filing an application for disability benefits with Social Security. As we discussed, Novant Health referred you to us. Here are the forms that we talked about. Please sign the second set, and mail them back to us in the stamped envelope. Your copy is attached to this letter for you to keep.

When your return them, QRS will obtain your medical records and evaluate your case. We will then discuss everything with you, and tell you if we think we can help you obtain benefits. If we think you have a good case, we will assist you with the entire process. Novant Healthcare provides this service to you free of charge.

As soon as we get these signed papers back from you, we will begin working on your case. If you wish to move forward with an application, I will be your Disability Case Manager, and your main point of contact through the process. The attached forms allow us to start evaluating your condition(s) and start the application process. To go forward you must sign and return these:

- Appointment of Representation (SSA-1696). This form tells Social Security that if a case is pursued, we will be acting as your representative, and that no fee should be charged to you. Please sign where indicated, by the red arrow.
- "Dear Social Security" Letter. This form protects the retro-activity of your potential claim.
- Designation of Authorized Representative allows us to pursue Medicaid benefits for you.
- Some of the remaining forms allow us to collect your medical records, and other information about your claim. Others give your permission for us to provide your information to Social Security and other parties related to your claim. If you have any questions about any of these forms please call me at 336-600-1724 so we can discuss them.

I will be contacting you after I get your forms back, and we receive some of your records. Please feel free to give me a call at 336-600-1724 if you have any questions. Again, please sign and mail these forms right away using the enclosed stamped envelope. There is a red arrow every place you need to sign. We look forward to hearing from you.

Sincerely,

Lila Canon

Disability Case Manager

**Quality Reimbursement Services**
P.O Box 746, Kernersville NC 27284
Ph.: 336-600-1724 / Fax.: lila@qrs-ssclaims.com

Social Security Administration

**Please read the instructions before completing this form.**

Form Approved
OMB No. 0960-0527

| Name (Claimant) (Print or Type) | Social Security Number |
|---|---|
| lilatest | |
| Wage Earner (If Different) | Social Security Number |
| | |

**Part I** **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, Michael Gaboury, P.O Box 746, Kernersville NC 27284
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title I (RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative Is _____
(Name of Principal Representative)

| Signature (Claimant) | Address , | |
|---|---|---|
| Telephone Number (with Area Code) | Fax Number (with Area Code) | Date 12/16/2015 |

**Part II** **ACCEPTANCE OF APPOINTMENT**

I, Michael Gaboury , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney ☐ I am a non-attorney eligible for direct payment under SSA law. ☒ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

| Signature (Representative) | Address P.O Box 746, Kernersville, NC 27284 | |
|---|---|---|
| Telephone Number (with Area Code) 336-600-1724 | Fax Number (with Area Code) | Date 12/16/2015 |

**Part III** **FEE ARRANGEMENT**

(Select an option, sign and date this section.)

Charging a fee and requesting direct payment of the fee from withheld past-due benefits. (SSA must authorize the fee unless a regulatory exception applies.)

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits -I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** -By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a thirdparty entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☒ **Waiving fees from any source** -I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

| Signature (Representative) | Date 12/16/2015 |
|---|---|

Form Approved
OMB No. 0960-0623

**WHOSE *Records to be Disclosed***

NAME
lilatest

SSN | Birthday

# AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

**I voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange)**:**

**OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including* , and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

**FROM WHOM**

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

**TO WHOM** **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process**. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

**PURPOSE** Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether **I am capable of managing benefits ONLY** (check only if this applies)

**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re disclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

**PLEASE SIGN USING BLUE OR BLACK INK ONLY**

**INDIVIDUAL authorizing disclosure**

**SIGN** ▶

**IF not signed by subject of disclosure, specify basis for authority to sign**

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

| Date Signed | Street Address | | |
|---|---|---|---|
| Phone Number (with area code ) | City | State | ZIP |

**WITNESS** *I know the person signing this form or am satisfied of this person's identity:*

**SIGN** ▶

Phone Number (or Address)

**IF** needed, second witness sign here (e.g., if signed with "X" above)

**SIGN** ▶

Phone Number (or Address)

*This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.*

Social Security Administration

Form Approved

**Consent for Release of Information**

OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. (*signifies a required field).

**TO: Social Security Administration**

| lilatest | | |
|---|---|---|
| ***My Full Name** | ***My Date of Birth (MM/DD/YYYY)** | ***My Social Security Number** |

I authorize the Social Security Administration to release information or records about me to:

| ***NAME OF PERSON OR ORGANIZATION:** | ***ADDRESS OF PERSON OR ORGANIZATION:** |
|---|---|
| Michael Gaboury | Quality Reimbursement Services |
| | P.O Box 746 |
| | Kernersville, NC 27284 |

***I want this information released because:** It is in support of my disability application and benefit management which is clearly a program purpose.

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my **file (you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

**I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.**

***Signature:** _____ ***Date:** 12/16/2015

***Address:** ,

**Relationship (if not the subject of the record):** _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

| 1.Signature of witness | 2.Signature of witness |
|---|---|
| Address(Number and street, City, State, and Zip Code) | Address(Number and street, City, State, and Zip Code) |

# Protective Writing CFR 20 §416.340

*Filing Date Based Upon a Written Statement or Oral Inquiry*

lilatest
**(Name of Claimant)** **(DOB)** **(SSN)**

,

Dear Social Security,

I plan to file an application for SSI disability benefits, Social Security disability benefits, or both within sixty days from the date I or my representative delivers this by mail or fax to you. I understand that if I do not complete my application within sixty days my claim will have a later filing date and I may lose benefits.

Sincerely,

Signature

12/16/2015
Date

## Authorization to Disclose Protected Health or Billing Information

**Patient Information: I give permission to release the health information of:** **(One patient per form)**

Patient Name: lilatest
Date of birth: _____
Street Address: , _____
Last 4 numbers of SSN: _____
City, State, Zip: , _____
Telephone: _____
Email address: _____

*Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.*

| **Release Information From:** | **Release Information To:** |
|---|---|
| | Quality Reimbursement Services, Inc. |
| (list applicable Facility(s) and/or Practice(s)) | (Name of facility, person, company) (Relationship) |
| | Michael Gaboury, Novant Contractor |
| | (Street address or PO Box, City, State, Zip code) P.O Box 746, Kernersville, NC 27284 |
| | (Phone number) 336-600-1724 |

**Purpose of Release (check reason):** ☐ Request of individual / personal ☐ Insurance ☒ Disability ☐ Workers Compensation
☐ Legal purpose including discussions & proceedings ☐ Other: _____

**Must fill in dates of treatment for records to be released:** Treatment dates FROM: _____ TO: _____

**Hospital (check all that may apply):**

☐ **Hospital Abstract**

- ☒ History & Physical
- ☒ Discharge Summary
- ☒ Operative Reports
- ☒ Consultation Reports
- ☒ Diagnostic Test Results
- ☒ Medications
- ☒ Allergies
- ☒ Physician Orders
- ☐ Progress Notes
- ☒ Emergency Record
- ☒ Cardiac Reports/EKG
- ☒ Laboratory Reports
- ☒ Radiology/X-Ray Reports
- ☒ Pathology Reports
- ☒ Billing Information
- ☐ Other: _____

☐ Entire Record (not including psychotherapy notes)

**Office/Clinic (check all that may apply):**

☐ **Office / Clinic Abstract**

- ☐ Office Visits
- ☐ Physical Exam
- ☐ Consultation Reports
- ☐ Diagnostic Test Results

☐ Laboratory Reports
☐ Radiology Reports
☐ Medications
☐ Billing Information
☐ Other: _____

☒ Entire Record (not including psychotherapy notes)

**Format (only select one):**
☐ Paper copy (charges may apply) ☒ Electronic copy
☐ CD (charges may apply) ☐ Other: _____

**Delivery Method:**
☐ Reg. US Mail ☐ Pick-up ☒ Email
☐ Other: _____

**I understand that:**

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

**This permission expires 90 days after the date of my signature unless another date or event is written here:** 01/04/2018

**Signature:** _____ **Print name:** lilatest **Date/Time:** 12/16/2015

**Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.**
**Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):**
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Parent ☐ Next of Kin
☐ Other: _____

**Signature of minor:** _____ **Print name:** _____ **Date/Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

***For office use only***
Date of release: _____ via ☐ mail ☐ fax ☐ other_____ ☐ ID verified ☐ DL/Other ID___
NH Employee Name & Title: _____ NH Employee User ID: _____ Date/Time: _____

# HIPAA AUTHORIZATION FORM

I, lilatest

Hereby authorize the use or disclosure of my protected health information as described below:

## I. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Michael Gaboury of Quality Reimbursement Services, P.O Box 746, Kernersville, NC 27284

is authorized to disclose the following protected health information to _____

## II. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The information that may be disclosed is:

All information pertinent to my disability application including but not limited to my medical records.

## III. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is:

Obtain and verify disability benefits administered by the Social Security Administration.

## IV. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on 12/16/2015 and expires on 12/16/2020

## V. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. Written notice can be provided to *QRS, PO Box 661432, Arcadia CA 91006*. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By:  _____ Date: 12/16/2015

QRS QUALITY REIMBURSEMENT SERVICES Healthcare Consultants

**Multi-Part Consent for the Release of Confidential Information**

lilatest _____ _____ _____

**(Name of Claimant)** **(DOB)** **(SSN)**

This form gives my permission for Michael Gaboury of Quality Reimbursement Services, Inc. to share my health and claims information with certain other parties. I give my permission only for the parties I select below. I understand that this is my decision and that I can change my mind at any time. If I do change my mind, I will make a request in writing to cancel this consent. I will mail this request to Michael Gaboury, P.O Box 746, Kernersville, NC 27284. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

| Yes | No | Third Party |
|---|---|---|
| ☒ | ☐ | Social Security Administration |
| ☒ | ☐ | Examiners selected by the Social Security Administration to evaluate me |
| ☒ | ☐ | Business associates selected by QRS to help with my claim |
| ☒ | ☐ | Medical or Psychological experts selected by QRS to help with my claim |
| ☒ | ☐ | Any doctor, hospital, or clinic where I have been treated or examined or has my records |
| ☒ | ☐ | Any Novant facility at which I have been treated in the past three years |

| Yes | No | Types of Information | Yes | No | Types of Information |
|---|---|---|---|---|---|
| ☒ | ☐ | Demographic | ☒ | ☐ | Lab/X-Ray Reports |
| ☒ | ☐ | Assessment | ☒ | ☐ | Admit/Discharge Dates |
| ☒ | ☐ | Physical Exam | ☒ | ☐ | Release/Discharge Summary |
| ☒ | ☐ | Treatment Plan(s) | ☒ | ☐ | Housing Information |
| ☒ | ☐ | Medications | ☐ | ☐ | |
| ☐ | ☐ | Other : Please describe: | | | |

**Date, Event or Condition when Consent Expires**: Five years from the date of signing shown below.

I understand that medical treatment services are NOT contingent upon or influenced by my decision to permit the information release. I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996(HIPAA)and45CFR parts 160 and 164,State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

**The information I authorize for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immuno deficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

_____ 12/16/2015 _____ _____

Signature of claimant Date Witness (if signed with X) Date

_____ _____ _____

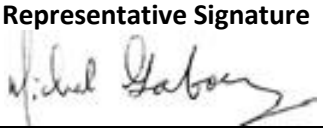
Signature of legal guardian, If required Relationship to claimant

# Designation of Authorized Representative

**You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace or the Department of Social Services in the County where you live. If you're a legally appointed representative for someone on this application, submit proof with the application.**

| | | |
|---|---|---|
| **1. Name of Applicant/Beneficiary** | lilatest | |
| **2. Name of Authorized Representative** | Michael Gaboury | |
| **3. Address** | | |
| **4. City** | **5. State** | **6. Zip code** |
| **7. Phone Number** | | **Language Preference** |

- **I understand that by signing this authorization, I am allowing the above named individual to sign my application, complete my re-enrollment/redetermination, get official information about my case status, and act for me on all future matters with this agency.**
- **I understand that by signing this authorization, my authorized representative may view and discuss any information contained in my case file or pertaining to my case <u>other than information from another source specifically designated as "Confidential" or "Do Not Release"</u>).**
- **I understand that my authorized representative and I are responsible for any incorrect or incomplete information provided.**
- **I undestand that I may revoke this designation of Authorized Representative at any time.**

| | |
|---|---|
| **Applicant/Beneficiary Signature** | **Date** 12/16/2015 |
| **Authorized Representative Signature**  | **Date** 12/16/2015 |

Patient Name: lilatest

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

| NAME | ADDRESS | PHONE NUMBER (with area code) | DATE FIRST SEEN OR ADMISSION DATE | DATE LAST SEEN OR DISCHARGE DATE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

| NAME OF MEDICINE | WHY YOU TAKE IT | PRESCRIBED BY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any medical tests you had or are going to have in the future.

| NAME OF TEST | PROVIDER WHO SENT YOU | DATE(S) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |