TriHealth Physician Office General Consent

Patient Name:_____ **Date of Birth:**_____ **Sex:** ☐M ☐F

Address: _____ **Primary Phone Number:**_____
Street

_____ **Secondary Phone Number:**_____
Street Line 2

_____
City, State Zip Code

Consent to Treat: I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by employees, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its subsidiaries (hereinafter "TriHealth").

I understand that Ohio law gives me the right to have an HIV test performed on me anonymously (my identity will be unknown) but that Ohio law does not require health care facilities to make anonymous HIV testing available. TriHealth does not provide anonymous HIV testing. By signing below, I acknowledge and agree that I am waiving my right to an anonymous test and that any HIV test ordered on me within TriHealth will be performed on a non-anonymous basis. In other words, my identity and test results will be maintained in my confidential TriHealth medical record and may be known to the healthcare providers who are treating me.

I understand that my protected health information will be used by TriHealth, as necessary, for my treatment, to obtain payment for this treatment, and for the health care operations of TriHealth. I also understand that my protected health information will be disclosed to other TriHealth affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment and for health care operations of TriHealth.

I understand that TriHealth will warn the appropriate authorities and/or other individuals if my TriHealth care giver determines that I am a harm to myself or to others.

I have read the above or had it read to me, and I certify that I fully understand the contents of this consent.

_____	_____	_____	_____AM/PM
Patient or Legal Representative Signature	**Relationship of Legal Representative (if applicable)**	**Date**	**Time**

Payment and Insurance Reimbursement: TriHealth will bill your insurance company (including Medicare) for services provided. TriHealth **DOES NOT** accept responsibility for collecting or failing to collect insurance claims, and you

acknowledge that you are responsible for payment for any services provided and that you will pay and all charges due and owed to TriHealth (including any co-pays and/or deductibles).

TriHealth will initiate payment of your claims for benefits. In order to do this, it is necessary for all responsible parties to give us certain rights and permissions.

1) I (as patient or as agent of the patient) hereby assign and transfer all right of third party payer benefits for services rendered to me to TriHealth and authorize any insurance or third party payments to be made directly to TriHealth. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions.

2) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under the terms of any other carriers, is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services and any other services to TriHealth and authorize TriHealth to submit a claim to Medicare or other third party payor for payment. Any assignment of benefits is limited to the Medicare allowed charge for physician services or to an amount not to exceed the Hospital's regular charges.

3) I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by third payors, and I will pay any and all charges due and owing TriHealth in accordance with its regular rates, terms and policies.

I have read the above or had it read to me, and I certify that I fully understand the contents of this consent.

_____	_____	_____	_____AM/PM
Patient or Legal Representative Signature	**Relationship of Legal Representative (if applicable)**	**Date**	**Time**

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that TriHealth give you a Notice of Privacy Practices that describes how TriHealth will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I received a copy of the Notice of Privacy Practices.

I have read the above or had it read to me, and I certify that I fully understand the contents of this consent.

_____	_____	_____	_____AM/PM
Patient or Legal Representative Signature	**Relationship of Legal Representative (if applicable)**	**Date**	**Time**

STAFF: If the patient did not acknowledge receipt of Notice above, you must document below your efforts to obtain the patient's acknowledgment and the reason why it was not obtained: