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.

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

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.

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

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.

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date

Staff: If the patient did not sign the Acknowledgment of Receipt of the Notice above, you must document below your efforts to obtain the patient's acknowledgment and the reason why it was not obtained and scan the consent into the patient's electronic chart.

The staff member attempted to give the Notice to the patient but the patient did not sign the acknowledgment above because (complete below):

_____ Patient refused to sign

_____ Other reason (Staff: insert reason on following line):

INVOLVEMENT IN CARE

Patient's Name _____Date of Birth_____

Last Four Digits of Social Security Number _____

I agree that any TriHealth Affiliated Physician Practice ("Healthcare Provider") where I am a patient may disclose my protected health information ("PHI") at anytime to the following individual(s) who are involved in my care:

Name _____ Name _____

Address _____ Address _____

Telephone _____ Telephone _____

Relationship to Patient_____ Relationship to Patient_____

I acknowledge the following statements: The individual(s) named above are involved in my healthcare or its payment; All of my PHI is relevant to the specified individual(s) for my care or payment; and I agree that my Healthcare Provider may disclose my PHI to the individual(s) specified above.

I understand that disclosure of my PHI will include information on drug or alcohol treatment, abuse or conditions, and/or psychiatric or psychological conditions or treatment, and/or HIV related conditions, if any and agree to release of this information.

I understand that if at any time I no longer want Healthcare Provider to communicate with the individual(s) specified above, I will immediately notify them in writing by sending a letter to my Healthcare Provider's office.

I understand that Healthcare Provider may verify the identity of the individual(s) named above prior to disclosing any of my PHI. I also understand and agree that nothing in this request for involvement is intended to limit or alter Healthcare Provider's ability to disclose PHI to individuals not listed on this form in accordance with professional judgment and applicable law.

CONTACT INFORMATION FOR PHONE CALLS

Preferred contact number: □ Home □ Cell □ Work _____

Check your preferences below:

You may leave PHI on my answering machine/voice mail □Yes □No

You may leave PHI with an adult who answers my home phone □Yes □ No

You may leave the following: □ Test or lab results □ Appointment information

□ Detailed message □ A response to my inquiry or questions

_____ _____

Patient Signature Date

□ I DO NOT wish to specify any individuals with whom my Healthcare Provider may share my PHI.

_____ _____

Patient Signature Date

Rev 11/2012

PATIENT INFORMATION

Date_____

Patient's Name_____

Date of Birth_____ Age_____ Sex (circle one): M F

Street Address_____

City, State, Zip Code_____

Home Phone_____Work Phone_____

Cell_____ Permission to leave a message: **YES or NO**

Social Security #_____ Marital Status: (circle one) **M S W D**

Primary Language _____ **Ethnicity (circle one):** Decline to Respond Hispanic/Latino Not Hispanic/Latino

Race (circle one): Decline to Respond American Indian/Alaska Native Asian Black/African American
Hawaiian/Pacific Islander White Other Race

Patient's Employer_____Occupation_____

Spouse's or Parent's Name_____

Spouse's or Parent's Employer_____Employer Phone_____

Contact in Case of Emergency_____Phone_____

Family Physician_____Referring Physician_____

Preferred Pharmacy (include address): _____

Pharmacy Phone _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE_____
POLICY HOLDERS NAME_____DATE OF BIRTH_____

NAME OF SECONDARY INSURANCE_____
POLICY HOLDERS NAME_____DATE OF BIRTH_____