TriHealth, Inc.
Physician Office Consent

Consent to Treat: I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examinations, administration of medications, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by office personnel, including physicians, nurses, and assistants.

Health Information Privacy: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that provides protection for your personal health information. I acknowledge that:

1) My personal health information can and will be used by this practice, as necessary, for treatment, to obtain payment for this treatment, and for the health care operations of the practice (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) My personal health information will be disclosed to other TriHealth affiliates for the purpose of furthering my treatment;
3) My physician will warn the appropriate authorities and/or other individuals if he/she determines that I am a harm to myself or to others;
4) My picture or other type of recording may be taken by employees or providers of the practice for reasons including, but not limited to, patient identification, assistance in diagnosis/treatment, documentation of conditions present upon arrival, and practice internal purposes.

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

Payment and Insurance Reimbursement: This office will bill your insurance company (including Medicare) for services provided. This office 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 any and all charges due and owed to the practice (including any co-pays and/or deductibles).

The practice and the physicians providing services to you will initiate payment of your claims for benefits (and may also process appeals from decisions related to your claims and benefits). In order to do this, it is necessary for all responsible parties to give us certain rights and permissions;

2) I (as patient or as agent of the patient) hereby assign and transfer all rights of third party payor benefits for services rendered to me to the practice and/or its physician(s) and authorize any insurance or third party payments to be made directly to the practice and/or its physician(s).

3) 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 the physician(s) and/or organization(s) furnishing the services and authorize such physician(s) and/or organization(s) 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.

4) I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by third party payors, and I will pay any and all charges due and owing TriHealth, Inc., its subsidiaries, and/or its physician(s) in accordance with their regular rates, terms and policies.

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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

One of the requirements of HIPAA is that we give you a Notice of Privacy Practices that describes your rights and protections regarding your personal health information.

I received a copy of the TriHealth Physician Practices' Notice of Privacy Practices.

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

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

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