General Consent
通用同意书

Patient Name (病人姓名): _____

Date of Birth (出生日期): _____ **Sex (性别):** ☐ **M / 男** ☐ **F / 女**

Address (地址): _____
Street (街道)

_____
Street Line 2 (街道行 2)

_____
City, State Zip Code (城市，州邮政编码)

Primary Phone Number (联系电话一): _____

Secondary Phone Number (联系电话二):_____

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 and/or contracted personnel, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its affiliates and subsidiaries (hereinafter "TriHealth").

同意治疗：本人，_____，同意由TriHealth及其附属或分支机构（以下简称"TriHealth"）的正式员工和/或合同工（包括但不限于医师、护士和医助）实施检查、诊断以及一般医疗护理和治疗（包括但不限于：体检、用药和接种疫苗、记录和/或拍摄影像用于诊断和/或治疗用途、拍摄X-光片、抽血、诊断性试验、实验室试验和其它小型手术）。

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.

我知道：俄亥俄州法律赋予我以匿名方式（即无人知晓我的身份）进行HIV测试的权利，但是俄亥俄州法律并未强制要求医疗保健机构必须提供匿名HIV测试服务。TriHealth并不提供匿名HIV测试服务。通过在下方签名，我表示知晓并且同意：我放弃进行匿名HIV测试的权利，并且我在TriHealth即将进行的HIV测试将不会基于匿名的方式实施。换言之，我的身份和测试结果将会保存在我在TriHealth的保密医疗记录中，对我进行治疗的医疗服务人员可能会知晓这些信息。

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.

我明白，TriHealth 在有需要时将会使用我受保护的健康信息，以便对我进行治疗、收取治疗费用，以及出于TriHealth医疗保健服务运营管理之目的。我也明白我受保护的健康信息在有需要时将会披露给TriHealth的其它附属机构，用于对我进行进一步治疗，以及出于 TriHealth 医疗保健服务运营管理之目的。

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

我明白，如果我在TriHealth护理人员确认我对自己或他人构成危害，TriHealth将会通知有关当局和/或其他个人。

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date
病人本人（如满或超过 18 周岁）或其法定监护人（如病人为未成年人）签名 日期

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 any and all charges due and owed to TriHealth (including any co-pays and/or deductibles).

付款和保险报销：TriHealth将为所提供的服务向您的保险公司（包括Medicare））开具账单要求付款。TriHealth不对领取或未能成功领取保险索赔承担责任，您承诺负责对所提供的服务进行付款，并支付应归于和所欠TriHealth 的任何和所有费用（包括任何共付款和免赔额）。

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.

TriHealth 将会针对您的保险福利索赔启动付款流程。为此，所有责任主体需给予我们一定的权利和许可。

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.

1) 我（病人或病人代理人）在此将因我接受的服务而由第三方付款人提供的所有利益权力转让给 TriHealth；并授权任何保险费或第三方付款直接支付给TriHealth。本授权将向有关方披露治疗毒瘾或酗酒、与毒品相关的病情、酒精中毒、心理疾病和/或 HIV 相关疾病的信息。

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 payer for payment. Any assignment of benefits is limited to the Medicare allowed charge for physician services or to an amount not to exceed TriHealth's regular charges.

2) 兹证明，根据《SocialSecurityAct（社会保障法）》第XVIII条款或其它任何法规条款项，本人在支付申请中所提供的信息均正确无误。我要求：根据上述转让安排支付授权利益的相关款项。我将Medicare服务项目涵盖的应付利益转让给TriHealth，并授权TriHealth向Medicare或其它第三方付费人提出偿付要求。任何利益转让仅限于Medicare允许的医疗服务费用或最高额不超过 TriHealth 的常规收费的费用。

3 I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by third party payers, and I will pay any and all charges due and owing TriHealth in accordance with its regular rates, terms and policies. Such charges will be applied to my Miami University Bursar bill.

3) 我理解，对于我即将得到的医疗服务，我对第三方付款人不涵盖的任何服务费用承担付款责任，我将依据TriHealth常规费率、条款和政策，支付应归于和所欠TriHealth的任何和所有费用。此类费用将会通过本人的迈阿密大学收费账单（Miami University Bursar）向我收取。

4 I understand that if at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not limited to communications regarding appointment reminders, billings and payment for items and services, unless I notify TriHealth in writing. Such calls and text messages may be delivered via artificial or pre-recorded messages, automatic telephone dialing devices or other computer assisted technology, e-mail text messages, or by any other form of electronic communication from TriHealth, its affiliates, contractors, providers, or agents including collection agencies.

4) 我明白如果任何时候我提供了可联系我的手机号码，除非我书面通知TriHealth，否则这将代表我同意接收包括但预约提醒、账单以及项目和服务付款的通讯信息在内的电话呼叫或短信。此类电话和短信传送可以人工或预先录制好的信息、自动电话拨号设备或其它电脑辅助技术、电子邮件文本信息或任何其它电子通讯等形式，由 TriHealth 及其附属机构、合约商、供应商或包括收债代理商在内的代理人发送。

_____

Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor
病人本人（如满 18 周岁）或其法定监护人（如病人为未成年人）签名

_____

Date/Time
日期/时间

Acknowledgment of Receipt of Notice of Privacy Practices
《隐私条例通知回执》

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.
《健康保险流通及责任法案》（HIPAA）要求 TriHealth 向您发放《隐私条例通知》。该通知声明 TriHealth 如何使用和披露您受保护的健康信息，并对您的 HIPAA 隐私权利做出说明。

I received a copy of the Notice of Privacy Practices.
我收到《隐私条例通知》。

_____

Signature of Patient (if 18 years old or older) or Legal Guardian if Patient is a minor Date
病人本人（如满 18 周岁）或其法定监护人（如病人为未成年人）签名 日期

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.
员工：如果病人未签署上述《隐私条例通知回执》，您必须在下面记录您为获取病人确认所做的努力以及未能获取病人签字的原因，并扫描同意书放入病人电子记录册中。

The staff member attempted to give the Notice to the patient but the patient did not sign the acknowledgment above because (complete below):
员工尝试将《通知》递送给病人，但病人未签署上述回执，原因是（填写以下内容）：

____ Patient refused to sign
病人拒绝签字

____ Other reason (Staff: insert reason on following line):
其它原因（员工：在下行中填入原因）：