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 and/or contracted personnel, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its affiliates and 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 caregiver 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 any 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 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.

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.

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.

_____

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

_____

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.

_____

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):