University Hospitals
Medical Group

Consent Form

I. Authorization for Treatment

Patient/patient's legal representative, agree to permit performance of such diagnostic, evaluation and therapeutic procedures that the physician deems necessary for my treatment and care.

II. Authorization to Release Information

The undersigned hereby permits University Hospitals Medical Group, its physicians, affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payors and/or the Physicians' agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, performance improvement initiatives, risk management and/or as required by law.

I further understand that such information will be available to other University Hospitals Health System entities as may be necessary for the completion of claims for reimbursement to the appropriate health care insurer, agency or any third party, which may be liable for charges.

III. Assignment of Benefits

In consideration of services received, I assign the benefits payable for services rendered to the physician(s) or designated agents. I direct those insurers to pay such benefits directly to the physician(s) or designated agents. I agree to pay any and all fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

[If applicable]: I am aware that I am choosing to utilize a health care provider that is *not in network* with my insurance plan. Therefore, I accept financial responsibility for the out of network penalty determined by my insurance company.

_____ (patient's initials)

IV. Medicare/TRICARE/Champus Payment/NOPP

I certify that the information I gave if applying for payment under Title XVII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/ Champus/Humana Military Claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician(s) or their designated agents, or authorize such physician(s) or designated agents to submit a claim to Medicare for payment to me.

I acknowledge receipt of a copy of the Notice of Privacy Practices: ☐ Yes ☐ No

V. Certification

I certify that to the best of my knowledge and belief, the information provided is complete and correct. The assignment and consent is valid from the date of signature. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time that the Physician(s)' record retention period for this document expires. This notice must be received prior to release of information.

I AM THE PATIENT OR REPRESENTATIVE AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ THE ABOVE AND UNDERSTAND ITS TERMS.

_____ _____

Signature of Patient/or Legal Representative (Indicate Relationship) Social Security Number

_____

Print Name of Patient / Legal Representative

_____

Date