University Hospitals

Patient Name:

Provider:

ENC #: **MRN #:**

DOB: **Age:**

Gender / Sex: **Appointment Date:**

Authorization for Treatment

This is the consent form for you to authorize University Hospitals (UH) to provide Services to the Patient named above. UH performs Services in a variety of settings, including medical centers, doctor's offices, health centers, home care, and hospice. Those who provide the Services may not be physicians. Services may be provided by independent practitioners, including physicians, who are not employees or agents of UH. All of University Hospitals Health System, Inc. locations and providers are called UH in this form. UH is a teaching institution and healthcare personnel in training may be present and participate in providing care. UH is not responsible for the acts or omissions of providers who are not directly controlled by UH. As used in this form, Services are the diagnostic, therapeutic, medical, physician, nursing, technical, and/or surgical services and/or procedures and associated support, including, but not limited to, x-rays, photographs, and laboratory testing necessary for care and quality assurance. Services may be provided through telehealth, utilizing technology to connect me and/or data about me to providers who may not be in the same physical location. Except in some circumstances, such as an emergency, any Services will be performed after I have been informed of the benefits and material risks associated with such Services and I have given my verbal consent. I understand that the Services do not guarantee a specific outcome or recovery.

By signing below, I, as or on behalf of the Patient, consent to receive and authorize UH to provide the Services.

Authorization to Access & Release Information

I acknowledge receipt of the University Hospitals Notice of Privacy Practices, which describes how UH may access and/or release all or any part of Patient information (including, but not limited to, information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) for purposes required by State and/or Federal law; in cooperation with a law enforcement investigation; treatment, billing or collecting payment for Services, and/or health care operations, which include improving quality, accreditation, training and education, performance improvement initiatives, discharge planning, risk management, for research-related purposes, population health, including improvement of healthcare delivery and communications, participation in health information exchange(s), including Clinisync, patient registries, organ procurement organizations and clinical collaborations, or as otherwise authorized and for any other permissible purpose. UH retains patient medical records in accordance with applicable law. UH may, unless otherwise refused, photograph and/or audio or video record me or the Services I receive, including those in which I am identifiable. UH will own such images or recordings and may use them for any lawful purpose.

I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with both federal law and regulations. I release the Hospital from any liability that might result from the disclosure of this information. I may revoke this permission at any time.

Assignment of Benefits & Payment

I assign to UH, all benefits for all Services received or to be received. I direct the Patient's insurer(s) and other third parties to pay such benefits directly to UH and/or my physician(s). I hereby agree to pay any and all UH or affiliated provider fees that exceed or that are not covered by insurance coverage, including for Services deemed to be experimental or investigational, and waive any and all notices and demands in the event of non-payment. Subject to any applicable UH financial assistance policy, I understand and agree to pay the charges incurred by the Patient, including for personal use and/or convenience items, and hereby authorize the hospital to bill me or any other applicable party for such use. I authorize UH to pursue payment for services and appeal the denial of payment for services, on my behalf.

Medicare/TRICARE/Champus Payment

I certify that the information I gave is correct. I authorize any holder of medical or other information about the Patient 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 claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for professional services to the provider furnishing these services or authorize such provider to submit a claim to Medicare for payment to me. FOD_Printed 2020-08-18 15:03:42

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By signing this form, I acknowledge, as applicable:

For Medicare and/or Champus/Tricare beneficiaries, I have been provided with an unaltered copy of the notice from Medicare and/or Champus/Tricare regarding my rights as a Medicare and/or Champus/Tricare patient.

Authorization to Contact

I authorize UH, any of its affiliated providers, to contact me for any purpose by any means I have provided, including telephone, voicemail, text message, email, or similar communication methods, including to remind me about upcoming appointments, to provide information related to those appointments (e.g., cancellations), or to provide other educational information related to my care, including eligibility to participate in research studies. I acknowledge that these communications or messages may contain protected health information.

I consent to receive text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from UH and its business associates, including billing services, collection agencies, or other third parties for any purpose. I understand this consent to communications is not required to receive Services from UH and that data usage and other charges may apply.

I may revoke this consent to any or all of these communications at any time.

Patient Personal Property

I understand that UH is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except to the extent UH has already acted in reliance on this form. **I UNDERSTAND THAT CHANGES OR ALTERATIONS TO THIS FORM ARE NOT BINDING ON UH AND REFUSAL TO SIGN MEANS I MAY NOT RECEIVE SERVICES.**

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

Printed Patient Name	Hospital No.
Signature of Patient	Date / Time
Signature of Legal Representative, if patient is unavailable	Relationship / Date
Time	
Witness	Date / Time

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