



WASHINGTON HEALTH SYSTEM

WASHINGTON HEALTH SYSTEM (WHS) AUTHORIZATION AND CONSENT TO TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

I, \_\_\_\_\_ (Patient Name)

(or \_\_\_\_\_ acting on behalf of \_\_\_\_\_), (Name of Authorized Representative/Relationship) (Patient Name)

consent to the following:

CONSENT TO TREATMENT

- I consent to the rendering of medical care... I understand that the practice of medicine and surgery is not an exact science... I understand that absent emergency or extraordinary circumstances... I understand that many of the physicians on the staff of the WHS are not employees or agents of the WHS... I consent and willingly authorize the taking of photographs and/or audio-visual recordings... I authorize WHS, and its designees, which include its Physician Groups or The Washington Physician Hospital Organization, permission to use my information as described in Washington Health System Notice of Privacy Practices.

PERSONAL PROPERTY

- I understand WHS is not responsible for and does not insure for the loss of my personal property, including money, dentures, glasses, hearing aids, electronic devices, or any other items I wish to keep with me while I am a patient.

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY INSURANCE BENEFITS

- I authorize WHS to bill my insurance carrier and request such payments to be made directly to WHS. I certify that the information I have given about my insurance coverage or other payment sources is correct. I assign to WHS all rights to insurance payments or benefits to which I may be entitled for services provided to me by WHS. I authorize WHS to act on my behalf as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review. I authorize WHS to release any medical or other information about WHS services, or services provided by third parties, if required to obtain payment from my insurer or other payor and their agents to process payments.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- **I assign** all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
- **I understand** that any amounts not paid by my insurance are my responsibility. I am responsible for being knowledgeable of my benefit plan and the co-pays and deductibles that I will be required to pay.
- **I understand** if I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payor (insurance carrier) regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT**

- **I certify** that the information given by me in applying for payment under Title XVIII of the Social Security Act 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. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**MEDICAL ASSISTANCE CERTIFICATION STATEMENT**

- **I certify** that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

- I have had the opportunity to review/receive a copy of the "Notice of Privacy Practices at Washington Health System."
- **I consent** to Washington Health System providing medical or other information related to my treatment and/or services to my primary care/family physician(s) and other healthcare providers as necessary for referral, consultation, treatment and /or the provision of other treatment-related healthcare services to me.
- **I understand** this information may be maintained on electronic information systems or stored in various other forms, including regional, state and national Health Information Exchange (HIE), and that I can elect to opt out of HIE upon request.
- **I understand** I may be contacted by Washington Health System (WHS) by cellular phone, which may include the use of pre-recorded/artificial voice messages, and /or automated dialing device or by text messages or email in connection with any communication made to me or related to my accounts.

**MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)**

I am under 18 years of age and for the following reasons I am entitled under Pennsylvania law to consent to treatment for myself, and if applicable, for my minor children without the consent of any other person.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Marriage                                     | <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Pregnancy condition to be treated |
| <input type="checkbox"/> Mental health illness (14 yrs-18 yrs of age) | <input type="checkbox"/> Substance abuse      | <input type="checkbox"/> Sexually transmitted diseases     |

I have read this Authorization/Consent for TPO form or have had it read to me, and it has been explained to me. I am satisfied that I fully understand its content and significance.

_____	_____	_____
Signature	Date	Time

This patient is unable to consent due to:

<input type="checkbox"/> Mental Incompetency	<input type="checkbox"/> Physical Inability	<input type="checkbox"/> A minor under 18 years of age	<input type="checkbox"/> Other: _____
--	---	--	---------------------------------------

_____	_____	_____
Authorized Signature/Relationship	Date	Time