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, which may include routine diagnostic procedures and such medical treatment as the named attending physician(s), or others of the Washington Health System's Medical Staff consider to be necessary.
- **I understand** that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of the examination or treatment at Washington Health System (WHS).
- **I understand** that absent emergency or extraordinary circumstances, no substantial procedures will be performed unless I have had an opportunity to discuss them with the physician or health care professional to my satisfaction. Special consent forms may need to be signed for specific procedures. I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic course. I will not be involved in any research or experimental procedure without my knowledge or consent.
- **I understand** that many of the physicians on the staff of the WHS are not employees or agents of the WHS, but rather are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Further, I realize that among those who attend patients at WHS are medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care as a necessary part of their education.
- **I consent and willingly authorize** the taking of photographs and/or audio-visual recordings for the express purposes of medical treatment, planning and assessment unless I request otherwise. I understand that except for purposes of treatment, planning and assessment or unless otherwise required by law, such photographs and/or audio-visual recordings will not be released without specific authorization by me or my personal representative.
- **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. This includes information that might be related to drug or alcohol or psychiatric conditions and/or sexually transmitted diseases including HIV testing and other AIDS related testing information.

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. I understand that I take full responsibility for the safeguarding of any such articles in my possession.

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. I also authorize WHS to release any medical or other information required by my insurer, other payors and their agents. I also authorize WHS to release medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided to me.

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.

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.

☐ Marriage ☐ High School Graduate ☐ Pregnancy condition to be treated
☐ Mental health illness (14 yrs-18 yrs of age) ☐ Substance abuse ☐ Sexually transmitted diseases

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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:
☐ Mental Incompetency ☐ Physical Inability ☐ A minor under 18 years of age ☐ Other:_____

_____ _____ _____
Authorized Signature/Relationship Date Time