

ALLEGHENIES INDEPENDENT PHYSICIANS CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

SUMMARY: This form allows Alleghenies Independent Physicians to treat you, bill your insurance and confirm you have been given privacy information. This forms needs to be signed once on the front and once on the back and initialed once.

Consent to Medical Care

I, _____ (print name) consent to the provision of care that may include diagnostic procedures, medical treatment and/or admission, which my attending physician or his/her authorized agent may consider necessary or advisable. I understand that this care may include tests (including diagnostic images), examinations, medical treatments, taking photographs (including video recordings) and making audio recordings that may be used for internal medical and educational purposes. I understand that a separate consent form will be required when taking such photographs or recordings for external purposes such as commercial filming, television programs or marketing. If I have a religious objection to specific care to be provided, which may include taking photographs and making audio recordings, I may ask Alleghenies Independent Physicians to not provide such care. I understand that special consent forms may need to be signed for some procedures involving entry into the body. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential. Oral consent requires two witness signatures.

I also understand and agree that others, under the direction of the physician involved in my care, may assist or participate in providing hospital and/or medical care at those teaching facilities. This may include, but not be limited to, residents, fellows and medical/nursing students.

I give Alleghenies Independent Physicians and its designees permission to (1) use my medical information as described in Alleghenies Independent Physicians Notice of Privacy Practices (Notice) and (2) when applicable, dispose of, by appropriate means, any specimens, tissues, (such as blood samples or other fluids, etc.). Once disposed of, these specimens and tissues cannot be retrieved.

I understand that Alleghenies Independent Physicians and its designees may use such specimens or tissues, without my authorization (1) as part of its educational activities and programs and (2) for research purposes if the specimens or tissues are de-identified and use in accordance with applicable state and federal regulations. If the specimens or tissues are not de-identified, Alleghenies Independent Physicians shall not use them for research without my written authorization.

I have read this Consent to Medical Care section or have had it read to me, and it has been explained to my satisfaction.

Patient Signature Representative	Date	Signature of Alleghenies Independent Physicians Representative
Signature/Identity on behalf of patient / relationship Name	Date	Signature of Alleghenies Independent Physicians Representative

TPO- Financial Arrangements/Release of Information

I agree to the following terms of payment for services provided.

1a. I authorize Alleghenies Independent Physicians to bill my insurance carrier and request such payments to be made to Alleghenies Independent Physicians I certify that the information I have given about my insurance coverage or other payment sources is correct.

1b. I assign Alleghenies Independent Physicians all rights to insurance payments or benefits to which I may be entitled for services provided to me by Alleghenies Independent Physicians I authorize Alleghenies Independent Physicians to act on my behalf and as my representative to request reconsideration by my managed care plan or utilization review entity for both internal and external coverage or grievance review.

TURN OVER

1c. I authorize Alleghenies Independent Physicians to release any medical or other information about this visit and services provided by Alleghenies Independent Physicians, if required to obtain payment from my insurer or other payor and their agents. I also authorize Alleghenies Independent Physicians to release any medical or other information required by my insurer, other payors and their agents, government agencies and their designees for view of the care provided.

2. I assign all rights of benefits, insurance proceeds or other payments or judgments to which I may be entitled for physician services for interpretation of the 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.

3. I authorize information related to my care to be provided to my primary care/family physician(s) and as otherwise necessary for referrals, consultation, treatment and/or other treatment related to health care services to me.

4. I have been provided Alleghenies Independent Physicians Notice of Privacy Practices document. I also understand that additional copies of this Notice are available for my review upon request.

_____ **Patient Initials (required)**

5. I understand that my information may be released if required by local, state or federal law.

6. I understand that any amounts not paid by my insurance are my responsibility.

Medicare Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any 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 providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me.

Medicaid Certification

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

Acknowledgement of receipt – my signature acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS)/CHAMPVA and does not waive any of my rights o request a review.

Patient Valuables

I relieve Alleghenies Independent Physicians of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that Alleghenies Independent Physicians will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

Minor Able To Consent For Care (If Applicable)

I am under 18 years of age and for the following reason(s) _____, I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable for my minor children without the consent of another person.

_____ **Patient Initials (required if completing this section)**

I have read this TPO-Financial Arrangements/Release of Information section or have had it read to me, and it has been explained to my satisfaction.

Patient Signature Representative	Date	Signature of Alleghenies Independent Physicians Representative
Signature/Identity on behalf of patient / relationship Name	Date	Signature of Alleghenies Independent Physicians Representative

FOR OFFICE USE ONLY

Patient Name _____ Account Number _____

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices _____

Reason given by patient for failure to acknowledge receipt of Notice of Privacy Practices:

Previously Received Refused Other: _____

Episode of Care: _____ Date: _____

Episode of Care: _____ Date: _____