UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

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

Patient Name: [redacted]

Patient DOB: [redacted]

CHP-0318 11/22

Imprint Patient Identification Here

UPMC, for the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of the UPMC system that are located in Pennsylvania.

I. CONSENT TO TREATMENT

This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.

1. I, _____ (print or type name) on behalf of _____ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, mental health, drug and alcohol abuse treatment, medical treatment and/or admission to UPMC, including its hospitals, other health care facilities and physicians (all "affiliates"), which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask UPMC not to provide such care.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by UPMC for education, as well as, health care operations purposes.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at UPMC teaching facilities. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. If applicable, I give UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be retrieved. I understand and agree that UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows UPMC to use specimens/tissue for research purposes without my authorization if my identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my specimens/tissue in research if my identity is linked to the specimens/tissue.
5. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.
6. I understand and agree that UPMC may at its discretion provide certain services to me by means called "telehealth" all of which are covered by this authorization. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse "telehealth" services.
7. When a physician orders home health, hospice, or ancillary services they will be directed to a UPMC provider unless otherwise requested or required by patient's insurance. UPMC honors patient choice among providers of healthcare.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by 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 Service 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. My signature at the end of this consent 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 to request a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

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.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have been provided the UPMC Notice of Privacy Practices, either now or previously. _____ **Patient Initials (required)**
2. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.
3. UPMC may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc. Such information may include sensitive information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent permitted under state and federal law, UPMC (including its hospitals, staff, physicians and other entities and programs) may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own healthcare-related operations. This includes my consent for UPMC to share my substance use disorder (SUD) treatment information from my licensed UPMC SUD program including dates of service, name of treatment provider(s) and diagnosis.
5. I understand that UPMC may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or the provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to release patient and educational information to my home caregiver.

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6. I understand I may be contacted by UPMC by cellular phone, which may include the use of pre-recorded/artificial voice messages, and/ or an automated dialing device ("auto dialer") or by text message or e-mail in connection with any communication made to me or related to my accounts **Patient Initials** _____
7. I understand that my information may be released if required by local, state, or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates:

1. I authorize UPMC to bill my insurance carrier and request such payments to be made directly to UPMC. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to UPMC all rights to insurance payments or benefits to which I may be entitled for services provided to me by UPMC. I authorize UPMC to act on my behalf and 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.
3. I authorize UPMC to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also authorize UPMC to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.
4. 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, and/or rehabilitation 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.
5. I understand and agree that any hospital and physician charges not paid by my insurance are my responsibility. I understand that final billing will be made upon determination of all charges incurred, less any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in accordance with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information regarding UPMC's Charge Description Master, please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer 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.
7. If I make an application for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

VI. PATIENT VALUABLES

I relieve UPMC 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 UPMC 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.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in a County in which the care at issue is provided.

VIII. 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 any other person. _____ **Patient Initials (required if completing this section)**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.).

Patient Signature (Witness is required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	

Patient Registration Form

Patient Information

Name: _____ **Birthdate:** _____-_____-_____

SS#: _____-_____-_____ **Age:** _____ **Sex: M or F Marital Status M S W D Other**

Address: _____**City:**_____ **State:** _____ **Zip:**_____

Home Phone: ( )_____ **Work Phone: ( )**_____

Cell Phone: ( )_____ **Email Address**_____

Employer:_____ **Occupation:**_____

Emergency Contact:_____**Relationship:**_____**Phone:**_____

Nearest Relative:_____**Relationship:**_____**Phone:**_____

Primary Care Physician:_____ **Phone Number**_____

Address_____

Referring Physician_____**Phone Number**_____

Person Responsible for bill (**Self** if **over** age **18,** legal guardian if under age 18)

Name: _____ **Birthdate:** _____-_____-_____

SS#: _____-_____-_____ **Age:** _____ **Sex: M or F Marital Status M S W D Other**

Address: _____**City:**_____ **State:** _____ **Zip:**_____

Home Phone: ( )_____ **Work Phone: ( )**_____

Employer:_____ **Occupation:**_____

Relationship to Patient (only if different**):**_____

Primary Insurance (Please present card for verification)

Insurance Name:_____ **Copay Amount-PCP: $**_____**Specialty:$**_____

Address:_____**City:**_____**State:**_____ **Zip**_____

Subscriber Name:_____ **Sex: M or F Birthdate:** _____-_____-_____

Subscribers Address:_____**Phone #:**_____

Insurance ID#:_____ **Group#:**_____ **Effective date:**____-____-_____

SS#: _____-_____-_____ **Relationship to patient:**_____ **Employer:**_____

Patient Registration Form

Secondary Insurance (Please present card for verification)

Insurance Name:_____ **Copay Amount-PCP: $**_____**Specialty:$**_____

Address:_____**City:**_____**State:**_____ **Zip**_____
Subscriber Name:_____ **Sex: M or F Birthdate:** _____-_____-_____

Subscribers Address:_____**Phone#:**_____

Insurance ID#:_____ **Group#:**_____ **Effective date:**____-____-_____

SS#: _____-_____-_____ **Relationship to patient:**_____ **Employer:**_____