Rev. 12/16

FIVE RIVERS HEALTH CENTERS
GENERAL CONSENT AND AGREEMENT

Name: _____ MRN#_____

CONSENT TO TREATMENT: I consent to, and authorize Five Rivers Health Centers to provide, all necessary care, including examinations, testing and treatment. I also consent to such tests and procedures necessary for infection control.

TREATING PHYSICIANS: I understand that the physicians who render professional services to me at Five Rivers Health Centers may be independent practitioners and not employees or agents of the Centers. I agree that Five Rivers Health Centers is not responsible for the acts or omissions of physicians that are not directed or controlled by Five Rivers Health Centers and that these physicians' charges will be billed separately in addition to the centers' charges. I assign to these physicians any insurance and other benefits to which I am entitled for the services provided by them.

SUPPORTIVE SERVICES: I understand that supportive services such as behavioral health counseling, substance abuse screening and counseling, and/or case management services may be recommended to me by my physician based upon my presenting needs. I also understand that these services will be billed separately in addition to the physician and center charges. I assign to these behavioral health providers any insurance and other benefits to which I am entitled for the services provided by them.

RELEASE OF MEDICAL INFORMATION AND PRIVACY: I authorize Five Rivers Health Centers to furnish my medical information and records to Five Rivers Health Centers agents, other health care providers, and any insurer, compensation carrier, or governmental agency in order to provide appropriate medical care to me, or to aid in the billing and collection of my account, or to aid me in obtaining financial assistance. This authorization does not, however, authorize Five Rivers Health centers to furnish the following information (please list any desired exclusions, e.g. information regarding drug and alcohol treatment, psychiatric treatment, AIDS, AIDS related condition, HIV testing, or diagnosis and treatment of HIV): _____. I understand that I may revoke this authorization in writing delivered to Five Rivers Health Centers. I also understand, however, that such revocation will not apply to information released before the Centers receive notice of my revocation. This authorization will remain in effect until revoked by me.

I acknowledge that I received Five Rivers Health Centers Notice of Privacy practices which sets forth the ways in which my personal health information may be used or disclosed by Five Rivers Health Centers and outlines my rights with respect to such information.

FINANCIAL AGREEMENT AND ASSIGNMENT: I agree to pay Five Rivers Health Centers, as bills are presented and at Five Rivers Health Centers' prevailing rates, all charges which are not satisfied by insurance or other third-party payer. I assign to Five Rivers Health Centers all insurance and other benefits to which I am entitled for the services provided by Five Rivers Health Centers. I direct that all such benefits be paid directly to Five Rivers Health Centers. Should my account become delinquent, I agree to pay interest at the legal rate, from date of discharge. I authorize Five Rivers Health Centers to obtain a copy of my credit report and other necessary financial information. I agree that, to the extent permitted by applicable law; Five Rivers Health Centers is fully subrogated to all of my rights to receive compensation or benefits from any person or governmental entity for the centers' goods and services provided to me. I understand that, pursuant to section 3727.42 of the Ohio Revised Code, I am entitled to a list of Five Rivers Health Centers' usual and customary charges for selected services. I may obtain that list upon request.

COOPERATION WITH BILLING: I understand that although Five Rivers Health Centers may assist me in doing so, I am solely responsible for compliance with the provisions of my insurance policy, including verifying coverage and obtaining any required pre-admission certification. I agree to cooperate fully with Five Rivers Health Centers in billing my insurance and any other third-party payer, including, but not limited to, promptly responding to requests for information from Five Rivers Health Centers, or any insurer or other third-party payer. I also understand that in order to receive any financial assistance in paying my bill, I must promptly and truthfully complete all required applications, provide requested supporting documentation and fulfill all other requirements of the assistance program. I agree that my failure to cooperate in these matters may result in the denial of benefits or assistance. If any insurer or other third-party payer denies payment of Five Rivers Health Centers claim; I will promptly pursue all appeals processes available to me. I also authorize Five Rivers Health Centers to appeal such denial on my behalf. I agree, in order for Five Rivers Health Centers to service my account or to collect any amounts I may owe, Five Rivers Health Centers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, and may also contact me by sending text messages or e-mails, using any e-mail address I provide to use which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MEDICARE PATIENTS: I certify that any 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, agents or attorneys, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to the provider.

PERSONAL PROPERTY: I agree that Five Rivers Health Centers is not responsible for the loss of money or valuables I bring with me.

_____	_____	_____	_____
WITNESS	DATE/TIME	PATIENT/GUARANTOR/GUARDIAN	RELATIONSHIP

Reason for signature by person authorized to sign for patient in lieu of signature of patient:

❒ Minor (under 18) **❒ Mental Condition** **❒ Physical Condition**

❒ Verbal Consent ❒ Telephone Consent _____ _____ _____

Patient Name	Obtained from	Relationship

_____	_____	_____	_____
Witness	Witness	Phone Number	Date/Time