2021 AMBULATORY / OUTPATIENT FINANCIAL

AGREEMENT, CONSENT TO TREATMENT AND AUTHORIZATION FOR

RELEASE OF INFORMATION

I understand this document is a Financial Agreement, Consent to Treatment, and Authorization for Release of Information for outpatient treatment at physician offices and hospital clinics of UC Health ("Agreement"). "UC Health" includes all facilities and organizations that operate as part of the UC Health system, including but not limited to University of Cincinnati Medical Center, LLC, West Chester Hospital, LLC, Daniel Drake Center for Post-Acute Care, LLC, University of Cincinnati Physicians Company, LLC and all hospital clinics and physician practices affiliated with UC Health. The agreements made and consents given by me in this form are valid for one year unless otherwise indicated in this document or revoked sooner by me. I understand that except as expressly limited in this document, I may revoke all or any part of the agreements and consents contained in thisform at any time by submitting my revocation in writing to UC Health.

1. Financial Agreement

a. **Financial Responsibility**: Subject to applicable law and the terms and conditions of any applicable contract between UC Health and a third-party payer (such as an insurance company, an employer-sponsored group health plan, or Medicare or another governmental healthcare program), and in consideration of all healthcare services rendered or about to be rendered to me or the patient named below, I agree to be financially responsible and obligated to pay UC Health for the total charges of the services received that are not paid under the "Assignment of Benefits" made below. I also agree to pay UC Health, at the time of service, any applicable, actual or estimated co-payment or co-insurance for the healthcare services rendered during the visit(s) at UC Health.

b. **Assignment of Benefits**: In consideration of all healthcare services rendered or about to be rendered to me or the patient named below, I hereby authorize payment from and assign to UC Health all rights, title and interest in and to any benefits or amounts due from any and all insurance policies, employer-sponsored group health plans, and/or any other responsible private or governmental third-party payers in an amount not to exceed UC Health's regular and customary charges for the healthcare services rendered. I consent to any request for review or appeal by UC Health to challenge adetermination of benefits made by any private or governmental third-party payer. Except as otherwise required by law, I assume responsibility for determining in advance whether the services provided tome, or the patient named below, are covered by any private or governmental third-party payer.

c. **Claims Submission Certifications:** I understand the information in this document or otherwise given by me to UC Health will be used in submitting claims for payment for services rendered to me or the patient named below, and I certify that such information is correct. I authorize a copy of this document tobe used in place of the original, and the use of "signature on file" on all claims submissions. I agree to notify UC Health if any of the information I have provided in this document changes or is no longer accurate, and understand that I am responsible for notifying UC Health of the new or corrected information. I understand that I am responsible for notifying UC Health of any pre-certifications or referrals required by my health plans or the health plans of the patient named below. In the event any account becomes delinquent and collection activity is required to collect payment, I agree to pay all reasonable attorney fees and collection agency costs and/or fees associated with the collection of any unpaid balance.

d. **Independent Physicians:** I understand that some of the physicians who render professional services at UC Health are independent practitioners and are not employees or agents of UC Health. UC Health is not responsible for the acts or omissions of physicians who are not directed or controlled by UC Health.I further understand that I will be billed by the individual physicians for services they render to me or the patient named below.

e. **Hospital-Based Clinics**: Some of the UC Health outpatient clinics operate as Hospital-Based Clinics. I understand that a separate hospital facility charge will be billed to me or the health insurance plan in connection with the treatment and services provided by UC Health in such clinics. The hospital statement is for the facility charge which includes use of the space, utilities, nursing and medical assistant staff, and supplies. These are charges I would not incur if the clinic was not a Hospital-Based Clinic. The physician statement is for the professional services of the provider. I understand that I might owe a separate co-pay and/or co-insurance for the Hospital-Based Clinic facility charge. The amount of my payment responsibility will depend upon the actual services provided in the clinic.

f. **Telehealth Consultations**: If my healthcare provider and I decide to engage in a telehealth consultation, in which my visit will be conducted remotely via telehealth technology, I understand my healthcare provider may bill for services provided as part of the telehealth sessions. Telehealth billing information is collected in the same manner as a regular office visit. I understand I am financially responsible for each telehealth session, and it is my responsibility to check with my insurance plan to determine coverage.

g. **Signature:** I understand that by signing this document, I become liable for all amounts incurred for patient care and other related services rendered by UC Health.

2. Notice for Medicare Patients

a. **Patient's Certification, Authorization to Release Information and Payment Request**: I certify that the information provided by me, or the patient named below, in applying for payment under Title XVIII ofthe Social Security Act (Medicare), is correct. I authorize any holder of medical or other information about me or the patient named below to release to the Social Security Administration, the Center for Medicare and Medicaid Services, and/or its intermediaries or carriers any information needed to adjudicate or address any Medicare claim relating to the provision of healthcare items or services. Similarly, I authorize the Social Security Administration, the Centers for Medicare and Medicaid Servicesand/or its intermediaries or carriers to release information about me or the patient named below in orderto establish Medicare entitlement, or to adjudicate or address any Medicare claim relating to the provision of healthcare items or services. I request that payments of authorized benefits be made to me or on my behalf or on behalf of the patient named below. I assign the benefits payable for practitioner services to the practitioner or organization furnishing the services, or authorize such practitioner or organization to submit a claim to Medicare for payment to me. I understand that if, under Medicare program guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment as set out above under the "Financial Agreement".

3. Consent to Treatment

a. **Consent to Treatment:** I hereby consent to and authorize the administration and performance of medical treatment and/or diagnostic testing by UC Health as considered necessary for my condition, or the condition of the patient named below, as directed by the physician, healthcare practitioner, associates, assistants or designees as may be needed to carry out my treatment and/or testing or the treatment and/or testing of the patient named below. I understand that UC Health is a teaching facility, and I agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my physician(s), or the physician(s) of the patient named below, inthe performance of medical, surgical or diagnostic procedures/ treatment that the physician(s) consider necessary.

b. **Blood Tests and Samples:** I authorize UC Health to obtain blood samples for testing of communicable or sexually transmitted diseases including, but not limited to HIV and hepatitis, if a physician orders the test for diagnostic purposes for me or the patient named below or in the event a healthcare worker has been exposed to my blood or bodily fluids, or the blood or bodily fluids of the patient named below. I authorize UC Health and my physician, or the below named patient's physician, dentist, surgeon or podiatrist, to have the results of these tests. Except when an HIV test is performed in a medical emergency and the test results are medically necessary to avoid or minimize an immediate danger to me, or the patient named below, or others, I understand that in Ohio, I, or the patient named below,have the right to an anonymous HIV test.

c. **Additional Consents to Treatment for Ambulatory Surgical and Other Procedures:**

(1) For myself or for the patient named below, I voluntarily consent to care as a patient at UC Health and consent to and authorize the administration and performance of all medical treatment and procedures, the use and administration of any pharmaceutical products including contrast media, therapeutic agents, anesthesia and/or anesthetic agents and the use of any medically accepted diagnostic procedures that may be prescribed and deemed appropriate and necessary by the attending physician or associates or assistants of his or her choice.

(2) I further authorize UC Health personnel to take samples, specimens and cultures, to perform medically necessary laboratory, diagnostic tests and procedures and dispose of such in the customary fashion, and to take such precautions as may be necessary for my treatment and safety, or the treatment and safety of the patient named below, and the safety of others.

(3) I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of the medical or surgical treatment or examination to be rendered at UC Health. I understand that there may be some risks from radiation (X-rays) and some medicines if I am, or the below named patient is, pregnant. I know that it is my responsibility to discuss possible pregnancy with the physicians and to advise the technician before an exam.

(4) I understand that if I, or the patient named below, leave the UC Health facility against the advice of any physician or refuse treatment or medication, UC Health is not responsible for any ill effect the decision may cause.

d. **Telehealth Consultation:** If my healthcare provider and I decide to engage in a telehealth consultation, in which my visit will be conducted remotely via telehealth technology, I agree to the following: I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that the audio and/or video conferencing technology used to perform the consultation will not be the same as a direct patient/healthcare provider visit, because I will not be in the same room as my healthcare provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare information may be shared with other individuals for treatment, payment, and/or healthcare operations purposes such as for scheduling or billing. Others involved in my care may also be present during consultation other than my healthcare provider, and I will be informed of their presence in the consultation and will have the right to terminate the consultation at any time. I understand that electronic communications may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.). I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the audio and/or videoconferencing technology is not adequate for the situation. I understand there is no guarantee the telehealth sessions will eliminate the need to see my healthcare provider in person. I understand that the alternative to a telehealth consult/visit is an in-person visit. I understand I may ask questions prior to having a telehealth

consultation. By signing below, I acknowledge that I have read and understand the risks and benefits of a telehealth consultation, and I wish to proceed with a telehealth consultation.

e. **Right to Revoke:** I understand that I may revoke my consent at any time and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

4. Medical Records/Release of Information

a. **Release of Records**: I authorize the release of medical records information, and I specifically authorize the release of information concerning treatment relating to HIV testing, AIDS or AIDS related condition, treatment of mental health or psychiatric condition(s), and/or treatment of alcoholism or drug abuse to insurance carriers or their associates, third-party payers or their representatives, the Social Security Administration or other authorized governmental agency, and/or review organizations as deemed necessary to establish or verify my benefits entitlement, or that of the patient named below, for UC Health or physician claims for services rendered and to process payment claims and obtain reimbursement from such third-party payers for the health services provided. The authorization providedin this section will expire one year after the conclusion of my, or the below named patient's, healthcare services. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon.

b. **Release of Electronic Medical Records for Treatment Purposes**: I authorize the electronic release of medical records information, and I specifically authorize the release of all information concerning treatment relating to HIV testing, AIDS or AIDS related condition, and/or treatment of mental health or psychiatric condition(s), to other healthcare providers who utilize an electronic medical record system compatible with the UC Health records system only for the purposes of providing treatment to me, or the patient named below. The authorization provided in this section will expire one year after the date of discharge. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon. I understand that if I refuse or revoke this authorization, UC Health will not deny any treatment to me or the patient named below.

c. **Release of Drug and Alcohol Related Information**: I understand that under federal and Ohio law, the disclosure of medical records related to the diagnosis, prognosis or treatment of alcoholism, alcohol abuse or drug abuse require a separate written authorization that includes the following: name of the program making the disclosure; name of the individual or the organization to receive the disclosure; name of the patient; the purpose of the disclosure; the type and amount of information to be disclosed; the signature of the patient or person authorized to give consent; the date the patient or other authorizedperson signed the form; a statement that the consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it; and the date, event or condition upon which the consent will expire, unless revoked before that specified time. I further understand that this information will not be released without the separate written authorization described above.

d. **Photography:**

(1) I understand and agree that my image, or the image of the patient named below, will be photographed for purposes of identification, assisting in my treatment (including patient safety), and assisting in certain healthcare operations of UC Health, such as performance improvement programs.

(2) I consent to the photographing or videotaping of wound sites and/or appropriate portions of my body, or the body of the patient named below, for medical, scientific, or educational purposes as may be requested by my, or the below named patient's, physician as long as my, or the below named patient's, identity is not disclosed. I understand that I may request cessation of recordingand rescind consent for use up until a reasonable time before use.

(3) For patients receiving care in the shock resuscitation unit ("SRU"), I consent to audiovisual recordings of me/the below named patient or part of my/the below named patient's body while undercare of the hospital for quality improvement, staff education or performance improvement purposes. The images/recordings obtained for either purposes will be destroyed after 180 days.

e. **Electronic Prescribing:** I hereby consent to and authorize UC Health and its affiliates, including physicians or other prescribers providing treatment to me or the patient named below at a UC Health facility, to access or input prescription benefit or medication history for me, or the patient named below, on the Surescripts Network or other electronic prescription services.

f. **Electronic Medical Records:** I understand that the facility where I am submitting this document is part of UC Health. I understand that the medical records kept by UC Health are maintained in an electronic medical record system that is utilized by all of UC Health and accessible from all UC Health locations. I understand that medical records concerning my, or the below named patient's, conditions and treatment may be accessed at locations within UC Health other than the facility at which treatment is being provided. I authorize the release of information from the medical record to members of the medical staff, its allied health professionals, employees, other facilities and organizations of UC Health and its agents as well as to accrediting and licensing/regulatory entities who have agreed to keep such information confidential, for the purpose of continuity of care, reviewing or auditing the performance of this facility, its medical staff, its allied health professionals, its employees, and/or its agents or otherwise assisting this facility in either its administration or the rendering of patient care.

g. **Contact Information:** I have voluntarily given my cell phone, home phone and/or other contact number so that I may be contacted. I authorize UC Health or its agents to contact me at any telephone number associated with my account, including wireless telephone numbers or other numbers that may result in a charge to me, whether provided in the past, present, or future. I also authorize contacts and messages (including voice messages and/or text messages) by automated dialers and other mechanical and/or electronic devices, which may or may not leave messages, for any purpose regarding my account, including but not limited to, collection services, status updates and appointment reminders.

h. **NOTICE**: Medical records of UC Health are kept on file for the period of time designated in UC Health's document retention policy and then destroyed. I understand that every patient or his or her legal representative has a right to inspect and obtain a copy of his or her medical record. There will be a charge for this service.

Discrimination is Against the Law

UC Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UC Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UC Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Interpreting Department (513) 476-5682.

If you believe that UC Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Office of Patient and Guest Experience, 234 Goodman Street ML #0707, Cincinnati, OH 45219, Phone: (513) 584-6201, TTY number: 513-584-0565, Fax: 513-584-3816, UCHealthExperience@uchealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Patient and Guest Experience is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (513) 476-5682.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (513) 476-5682。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (513) 476-5682.

ملحوظة : إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان . اتصل على الرقم (513) 476-5682.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (513) 476-5682.

ВНИМАНИЕ! Если вы говорите по-русски, то можете бесплатно пользоваться услугами перевода. Звоните (513) 476-5682.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (513) 476-5682.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (513) 476-5682.

HUBACHIISA: Yoo afaan Oromoo dubbachuu dandeessu ta'e tajaajila gargaarsa afaanii kaffaltii malee argattu. Bilbilaa (513) 476-5682.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (513) 476-5682번으로 전화해 주십시오.

ATTENZIONE: Se parlate italiano, un servizio di assistenza linguistica gratuito è disponibile al seguente numero telefonico: (513) 476-5682.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(513) 476-5682まで、お電話にてご連絡ください。

LET OP: Als u Nederlands spreekt, kunt u gratis gebruikmaken van taalkundige diensten. Bel (513) 476-5682.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете безкоштовно скористатися послугами перекладача. Телефонуйте за номером (513) 476-5682.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (513) 476-5682.

Revised 1/9/2021

ACKNOWLEDGEMENT OF RECEIPT OF AMBULATORY / OUTPATIENT FINANCIAL AGREEMENT, CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF INFORMATION

BY SIGNING AND COMPLETING THE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT.

Signature:				**Date:**		**Time:**	
Printed Name:				**DOB:**			
Address:							
City		**State:**		**Zip Code:**			
Home Phone:		**Cell Phone:**		**Other Phone:**			

Person Signing:

- ○ Patient
- ○ Closest Relative
- ○ Legal Guardian
- ○ Minor years of age

OR

- ○ Other:

Which location do you have an upcoming service for?

- ○ **University of Cincinnati Medical Center**
- ○ **Daniel Drake Center for Post-Acute Care Campus**
- ○ **West Chester Hospital Campus**
- ○ **UC Health physician office/ambulatory office**

For UC Health use only: ☐ Documentation of authority on file (if required)

Employee name: Date:

Revised 1/9/2021

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES** the first time you receive care at UC Health. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

Patient or Patient's Legal Representative: Check appropriate box and sign.

- ◯ I have reviewed a copy of the Notice of Privacy Practices.
- ◯ I have previously reviewed a copy of the Notice of Privacy Practices.
- ◯ I do not want a copy of the Notice of Privacy Practices.

PATIENT/LEGAL REPRESENTATIVE | RELATIONSHIP TO THE PATIENT

Printed Name:

Date:

If your provider is located on the **University of Cincinnati Medical Center Campus**, **Daniel Drake Center for Post-Acute Care Campus**, **West Chester Hospital Campus**, return the completed acknowledgement form to UC Health through any one (1) of the following methods. For questions, call 513-298-7750.

- **Email:** wch-scanning@uchealth.com
- **Fax:** 513-298-7981
- **Mail:** West Chester Hospital, Medical Records, 7777 University Drive, Suite A, West Chester, OH 45069
- **In person:** At your doctor's office or at the Health Information Management Department address above on weekdays between 8 a.m. and 4:30 p.m. Picture identification is required.

Please contact your provider's office if you have any questions.

Disclaimer for electronic transmission

By submitting this form, I understand and acknowledge, that if I decide to complete these forms and send them back to UC Health via this email exchange, UC Health cannot control and is not responsible for any compromised transmission of the email from your email server, or any compromise of your information that occurs with your email server storage. If you prefer to communicate via encrypted email, please let us know that before sending the forms back, and we will send you an encrypted email which will also be encrypted when you respond with the forms. If you would rather fax or mail the forms, please use the fax number or mailing address listed above.

Click Here to Email Form

Below this line is for UC HEALTH staff use only if the patient or patient's legal representative has not acknowledged above. Employee: Check appropriate box and sign.

- ◯ Patient or Patient's Legal Representative refused to sign Acknowledgement.
  Explain:
- ◯ Patient or Patient's Legal Representative is unable to sign Acknowledgement.
  Explain:
- ◯ Patient or Patient's Legal Representative has previously acknowledged receipt of Notice of Privacy Practices.

Employee name: Date:

Reset Form