UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

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.

I. CONSENT TO TREATMENT

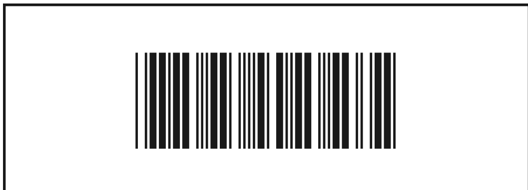
1. I, ______________________________________ **(print or type name)** on behalf of___________________________________ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, medical treatment by and/or admission to UPMC, including its hospitals, other 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.
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. I give UPMC and its designees permission to use my information as described in the *UPMC Notice of Privacy Practices*.
5. 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, 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.
6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

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 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.

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. 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.



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

1. I have been provided the *UPMC Notice of Privacy Practices*, which may have been provided to me during a previous visit..__________________________ **Patient Initials (required)**
2. I consent to access by any UPMC affiliate (including UPMC hospitals, staff, physicians providing services to me and other entities and programs) to my medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to my treatment and/or services. I also consent to UPMC providing such information 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. However, my specific consent to release behavioral health information will be obtained as required by law.
3. 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 about UPMC 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 UPMC to release any medical or other information required by my insurer, other payors and their agents. I also authorize UPMC 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.
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 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 that any amounts not paid by my insurance are my responsibility.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payor 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.

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 TO MEDIATE CLAIMS

I agree that any claim which may result from the care provided to me by the doctors, nurses and other health care providers in any UPMC facility shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me and any person making a claim on my behalf.

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 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 is valid for one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) except for behavioral health facilities, where a separate consent may be required for an encounter.

Patient Signature	Date	Signature of UPMC Representative
Signature/Identity on behalf of patient/relationship Name	Date	Signature of UPMC Representative

FOR OFFICE USE ONLY

Patient Name ________________________________ Account Number ____________________ MRN ____________________

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

Reason given for refusal: ☐ Previously received ☐ Patient did not specify ☐ Other: ________________________________