

A Service of Otsego Memorial Hospital

CONSENTS

Patient Name:	 Date of Birth: _	

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I HEREBY AUTHORIZE MUNSON HEALTHCARE OMH MEDICAL GROUP STAFF AND ITS REPRESENTATIVES TO RENDER ROUTINE HEALTH CARE TO MYSELF OR MY CHILD. I UNDERSTAND THAT ROUTINE HEALTH CARE IS CONFIDENTIAL AND MAY INVOLVE PROVIDER OFFICE VISITS WHICH INCLUDE HISTORY TAKING, EXAMINATIONS, AND ADMINISTRATION OF MEDICATIONS, DIAGNOSTICS SUCH AS LABORATORY OR RADIOLOGY SERVICES AND/OR MINOR PROCEDURES. I CONSENT TO THE TAKING OF PHOTOGRAPHS OF APPROPRIATE PARTS OF THE BODY DURING THE COURSE OF MY CARE OR THE CARE OF MY CHILD FOR THE INCLUSION IN THE MEDICAL RECORD OR FOR EDUCATIONAL PURPOSES.

I UNDERSTAND THAT MUNSON HEALTHCARE OMH MEDICAL GROUP HAS A TEAM BASED APPROACH TO MEDICINE AND A PROVIDER MAY REFER ME OR MY CHILD TO WORK WITH OTHER TEAM MEMBERS WITHIN MUNSON HEALTHCARE OMH MEDICAL GROUP, MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL OR A COMMUNITY SERVICE PROVIDER SUCH AS A CARE MANAGER, COMMUNITY HEALTH WORKER, PHARMACIST OR PHARMACY SPECIALIST, OR SPECIALTY CARE SERVICES. ALL OF THESE SERVICES WILL BE BILLED THROUGH MY INSURANCE AND MAY OR MAY NOT HAVE COST SHARE DEPENDING ON THE PLAN. CARE MANAGEMENT MAY BE SUPPLIED BY OTHER PROVIDERS AND MUNSON HEALTHCARE OMH WILL WORK WITH OTHER HEALTH CARE PROVIDERS TO MAKE SURE ONLY ONE PROVIDER IS BILLING FOR CARE MANAGEMENT AT ANY POINT IN TIME. AS WITH ANY SERVICE I MAY DECLINE AT ANY TIME.

IN CONSIDERATION OF THE SERVICES RENDERED, I HEREBY EXPRESSLY AGREE TO PAY IN FULL, ANY AND ALL CHARGES FOR PROVIDER SERVICES RENDERED AND MATERIALS FURNISHED TO OR FOR THE PATIENT BY THE MUNSON HEALTHCARE OMH MEDICAL GROUP AND MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL. I HEREBY ASSIGN PAYMENT DIRECTLY TO THE ABOVE HOSPITAL OF AUTHORIZED BENEFITS TO BE MADE IN MY BEHALF, NOT TO EXCEED THE BALANCE DUE OF THE PROVIDER'S REGULAR CHARGES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR CHARGES NOT COVERED BY THIS AUTHORIZATION UNDER THE PROVISIONS OF THE FEDERAL TRUTH IN LENDING LAW 7196.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

- I UNDERSTAND THAT AS PART OF MY HEALTHCARE, MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL USES HEALTH INFORMATION AND MEDICAL RECORDS DESCRIBING ALL ASPECTS OF MY CARE. IT IS USED FOR:
 - PLANNING MY CARE AND TREATMENT.
 - COMMUNICATING WITH HEALTH PROFESSIONALS INVOLVED IN MY CARE.
 - A SOURCE OF INFORMATION FOR BILLING.
 - A MEANS BY WHICH ANY PAYER CAN VERIFY THAT SERVICES BILLED WERE PROVIDED, AND ASSIST WITH OUR PROVIDERS BEING PAID FOR SERVICES AND CARE PROVIDED TO ME; AND A TOOL USED FOR ROUTINE HEALTHCARE OPERATIONS TO MEASURE THE QUALITY OF MY CARE.
- I ACKNOWLEDGE THAT (1) IF I AM A FIRST TIME PATIENT, I WAS OFFERED AND HAVE RECEIVED A COPY OF MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL'S NOTICE OF PRIVACY PRACTICES; OR (2) IF I AM NOT A NEW PATIENT TO MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL, I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES AT A PREVIOUS VISIT.
- I UNDERSTAND THAT MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL RESERVES THE RIGHT TO CHANGE THIS NOTICE AND WILL POST A COPY OF ANY REVISED NOTICE IN ITS WAITING ROOMS AND EXAMINATION ROOMS AND WILL PROVIDE ME WITH A COPY UPON MY REQUEST.
- I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES AND TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION IS USED OR SHARED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.
- I UNDERSTAND THAT MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.
- THE NOTICE OF PRIVACY PRACTICES IS POSTED IN A CLEAR AND PROMINENT LOCATION WHERE I AM ABLE TO READ THE NOTICE.
- I KNOW THAT I CAN ASK FOR A COPY OF THE NOTICE OF PRIVACY PRACTICES TO TAKE WITH ME.
- I WAS ABLE TO VIEW THE NOTICE OF PRIVACY PRACTICES ON THE FIRST DAY I RECEIVED HEALTH CARE SERVICES.
- I AM ABLE TO VIEW THE NOTICE ELECTRONICALLY AT THE MUNSON HEALTHCARE OMH WEBSITE AND MUNSON HEALTHCARE OMH PATIENT PORTAL.
- IF I CAME IN FOR HEALTH CARE SERVICES IN AN EMERGENCY TREATMENT SITUATION, I WAS ABLE TO VIEW THE NOTICE AS SOON AS REASONABLY PRACTICABLE AFTER THE EMERGENCY TREATMENT.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE	DATE	RELATIONSHIP TO PATIENT	