Capital Park Family Health Center
2365 Innis Road
Columbus, Ohio 43224
614-416-4325

HEART OF OHIO FAMILY HEALTH

Whitehall Family Health Center
882 South Hamilton Road
Columbus, Ohio 43213
614-235-5555

PATIENT CONSENT AND AUTHORIZATION

This consent is valid for one (1) year or sooner **if requested in writing.**

RECORD OF RECEIPT AND MESSAGE PERMISSION

1. I have received a copy of the HOFHC Patient Handbook including my rights and responsibilities ☐ YES ☐ NO
2. HOFHC is allowed to leave a message on my voicemail/answering machine ☐ YES ☐ NO
4. HOFHC is allowed to contact me via E-mail ☐ YES ☐ NO
5. I give permission for HOFHC to discuss my health information with the following person:

Name	Relationship to Patient	Phone Number

CONSENT TO MEDICAL CARE AND TREATMENT

While at Heart of Ohio Family Health Centers (HOFHC), I consent to all medical care, examinations, and tests determined to be necessary for me. Though I expect the care given to meet customary standards, I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me, I will not hold HOFHC or any individual responsible for any of the consequences. I understand that I am being established by HOFHC as a recurring patient to be provided a series of ongoing services based on my provider's orders.

RELEASE OF INFORMATION

I understand HOFHC may use my health information for a range of purposes including: insurance/payment eligibility verification, billing and collecting moneys due from me, private and public payers or their agents including insurance companies, managed care entities, my employer and state and federal government programs obtaining pre-admissions or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance or qualifications of physicians and health care ensuring compliance with legal, regulatory and accreditation requirements, performance of autopsies, and public health activities. I authorize HOFHC to receive or release my health information, whether written, verbal, electronic–including secured internet websites–or by facsimile to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care. I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize HOFHC to release health information to my family physician, referring physician or agency(ies) in order to facilitate continuity of care. I understand that the information shared with health care professionals as a result of this authorization will remain confidential. The preceding authorizations for release of medical information include authorization for the release of information regarding drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of HOFHC's Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for directory, disaster relief, or to provide information to family or persons involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of all insurance benefits to be made directly to HOFHC for services related to this encounter. I acknowledge that if the ID card present at the time of service is not valid, I will be responsible for payment.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS AND/OR COMMERCIAL INSURANCE BENEFITS TO PROVIDER

I certify that the information given by me in applying for Medicare payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release this information to my health insurers. I request that payment of authorized benefits be made on my behalf. I authorize HOFHC to bill Medicare Lifetime Reserve Days, as necessary. I assign the benefits payable for physician services (including emergency, radiology, pathology, dialysis, EKG, EEG, physical therapy, anesthesia and other hospital-based physician services) to the hospital-based physician or organization furnishing the services (if assignment is accepted) and authorize the physician or organization furnishing the services to bill Medicare, Medicaid, and/or commercial insurance a carriers for payments. I also assign the benefits payable for private and attending physician services to my private/attending physicians or his/her private practice organization, providing, however, that should my private/attending physician NOT ACCEPT THIS ASSIGNMENT AS PAYMENT IN FULL for his/her services, I understand I am responsible for full charges.

FIANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I agree to pay HOFHC for charges incurred including incidentals. I understand that charges due by the patient, but not paid within 30 days of billing may be subject to interest. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other providers who do not participate with my insurance plan. Non-covered services may also include those my physician determines medical necessary, but are later determined unnecessary by my insurance plan.

PERSONAL VALUABLES

HOFHC does not assume responsibility for any lost, stolen, or damaged personal items. I accept responsibility for items I choose to keep with me at HOFHC.

MEDICARE RIGHTS NOTIFICATION LETTER

If I have Medicare, I acknowledge receipt of the Medicare Rights Notification letter.

SOCIAL SERCURITY ADMINISTRATION RELEASE

I authorize the Social Security Administration to release to HOFHC information pertaining to my Medicare entitlement.

Printed Patient Name: _____ *Date:* _____

Patient/Guardian Signature: _____ *Date:* _____

Staff Signature: _____ *Date:* _____