



**CONSENT AND AUTHORIZATION - UMG**

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :

**CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT:** I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), is necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV. I can discuss this with my provider and tell him/her if I do not want to be tested for HIV. If test results are positive, they will be shared with me

**PHYSICIANS:** I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand that GHS is a medical teaching institution and that medical students and residents may be involved in my care under the supervision of an attending physician.

**ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:** If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to physician(s) not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as anesthesiologists, pathologists, and other private physicians). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.

**FINANCIAL AGREEMENT:** I understand that I am obligated to pay my account according to the regular rates and terms of GHS. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account for which I am responsible, I will receive a refund. I understand that GHS may obtain my credit report for review in collection of this account. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

**MEDICARE PATIENTS:** Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

**CONTACTING PATIENTS:** I hereby authorize GHS to contact me through the information provided at the time of registration.

**DISCLOSURE/USE OF HEALTH INFORMATION:** I understand that normal uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

**PHOTOGRAPHING:** I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE \_\_\_\_\_

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT \_\_\_\_\_

DATE \_\_\_\_\_ TIME \_\_\_\_\_

SIGNATURE OF WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

SIGNATURE OF WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)

**CHART COPY**