UPMC

UPMC - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO) IN NEW YORK

Imprint Patient Identification Here

I. CONSENT TO TREATMENT

This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.

1. I, _____ (print or type name) on behalf of _____ (patient name and relationship) give my permission to be treated. This may include examinations, tests and procedures, medical treatment, mental health, and drug/alcohol abuse treatment. This may include admission to UPMC hospitals, and other health care facilities under the care of a doctor and/or care provider (all "affiliates"), which they or their authorized agent (someone who has the power to act on their behalf), may think it is necessary or the best course of action. I understand specific 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 that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or by UPMC for education as well as health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me at UPMC teaching facilities. These may include but are not limited to doctors and/or care providers in training (residents and fellows), and medical/nursing students.
4. If it applies to me, I give UPMC permission to properly dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be recovered. I understand and agree that UPMC and those it chooses can use these specimens/tissue for educational purposes. I understand that state and federal laws let UPMC use my specimens/tissue for research without my permission as long as my identity cannot be linked to the specimens/tissue. If my identity is/can be linked to the specimens/tissue, I will be asked to give permission first.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment.
6. I understand and agree that UPMC may provide care or services to me through video, called "telehealth". Telehealth may include sending videos, sound recordings, images, pictures, and other types of information in real time, or it may be stored and forwarded through an application, or "web or mobile app". The telehealth provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse treatment "telehealth" services.
7. When a doctor and/or care provider orders home health, hospice, or additional services they will be directed to a UPMC provider unless you ask us not to or if it is requested by your insurance. UPMC honors patient choice for your providers of health care.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I confirm that the information gave when applying for payment under Title XIX of the Social Security Act is correct. I give permission to those who have medical or other necessary information about me to share it with the Centers for Medicare and Medicaid Services or its agents or carriers, as needed for this or any related Medicare claims. I ask that approved benefit payments to be made for me. I give permission to transfer the payments for doctors and/or care providers to them or their organization providing the services or give them permission to submit a claim to Medicare for payment for me. I confirm that I received an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS/CHAMPVA) and does not give up any of my rights to ask for a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I confirm that the information given in this consent is true, complete, and correct. I understand that federal and state funds will be used to pay for and settle this claim and that federal and state laws can be used to punish any false claims, statements, documents, or hiding of important facts.

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

1. I have received the UPMC Notice of Privacy Practices, either now or in the past.
2. I understand and agree that UPMC and the people it identifies can use my information as described in the UPMC Notice of Privacy Practices.
3. UPMC can store information about me and my care in different ways, including on computer systems, electronic media, paper, etc. This information may include sensitive information such as genetic testing information, abortion-related information, HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent allowed under state and federal law, UPMC hospitals, staff, doctors and/or care providers, and other facilities and programs may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own health care-related operations.
5. I understand and agree that UPMC may release my information, including but not limited to, automated notifications of encounters, to my primary care/family doctor(s) and other providers as is necessary for treatment, consultation, referral, and/or other treatment related health care services to me. However, to follow certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information - including genetic testing information, abortion-related information, HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to report any vaccine given to me to the New York Department of Health and to release patient and educational information to my home caregiver.
6. I understand and agree that UPMC may contact me using the contact information I have provided, including by phone (including cell phone), text message, and email to communicate with me about my care, scheduled services, and financial accounts. This may include pre-recorded messages.

7. I understand that UPMC is a research institution and may contact me with opportunities to participate in research studies in accordance with applicable laws. If I do not wish to be contacted about research opportunities, I can opt out by calling 412-624-1030 .
8. I understand and agree 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 give UPMC permission to bill my insurance company and I ask for those payments to be made to UPMC. I verify that the information I have given about my insurance or other payment sources is correct.
2. I give UPMC the right to insurance payments or benefits that I may be owed for services that UPMC has provided. I give UPMC permission to represent me and ask my managed care plan for an internal and/or external review process or an appeal of my coverage.
3. I give UPMC permission to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also give UPMC permission to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their chosen representative for review of the care provided to me.
4. I give UPMC the rights to benefits, insurance proceeds or other payments or judgments that I may be entitled to for hospital-based doctor and/or care provider services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services, and/or rehabilitation services to the doctor and/or care provider or organization providing the service. I also give permission to submit a claim for payment on my behalf to my insurance carrier.
5. I understand and agree that any hospital and doctor and/or care provider charges not paid by my insurance are my responsibility. I understand and agree that final billing will be made once all charges have been included, minus any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in line with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information about UPMC's Charge Description Master please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit sharing of the information to my payer about those services, I understand that a separate financial agreement will be put into place about the self-pay services and this section will not apply to those services.
7. If I apply for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is allowed to provide information as is necessary to determine if I am eligible.

VI. PATIENT VALUABLES

I release UPMC from any responsibility for any loss, damage, or theft of my personal property, including clothing, cash, jewelry, dentures, glasses, or other valuables that I choose to keep with me while I am a patient. I agree UPMC will not be responsible for replacing any lost, damaged, or stolen items that I choose to keep with me, or anything that is brought to me while I am a patient.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I understand and agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in the County where the care at issue is provided.

VIII. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____,
I am allowed under New York 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 Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me, and it has been explained to my satisfaction. I understand that pursuant to this TPO form, the component of my consent relating specifically to treatment may be valid for up to one (1) year from the date that I sign it and it applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) All other promises set forth in this agreement remain enforceable upon the expiration of the consent for treatment.

Patient Signature (Witness is required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	