

CONSENT FOR TREATMENT, PAYMENT  
AND HEALTH CARE OPERATIONS (TPO)

CHP-0318 03/17

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

- I, \_\_\_\_\_ (print or type name) on behalf of \_\_\_\_\_ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, mental health, drug and alcohol treatment, medical treatment 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. For licensed drug and alcohol facilities, this TPO will act as a consent for treatment only. Any disclosure of information would require a separate release of information. If I have a religious objection to specific care to be provided I may ask UPMC not to provide such care.
- 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 as well as health care operations purposes.
- 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.
- 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, these 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.
- I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.
- I understand and agree that UPMC may at its discretion provide certain services to me by remote means called “telehealth”. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The remote provider will determine whether the condition being diagnosed or treated is appropriate for telehealth.

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 Service 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. 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.

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.

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

- I have been provided the UPMC Notice of Privacy Practices, either now or previously. \_\_\_\_\_ **Patient Initials (required)**
- I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.
- I consent to access by any UPMC entities (including UPMC hospitals, staff, physicians providing services to me and other entities and programs) to all of my medical or other information maintained on electronic information systems or stored in various forms at individual UPMC entities and affiliates of UPMC that is necessary to provide treatment and/or services. I understand that UPMC will provide such information to my primary care/family physician(s) and others as is necessary for referral, consultation, treatment and/or the provision of other treatment related healthcare services to me. This consent also includes my specific consent for the release of mental health information as permitted by law, excluding information from programs governed by the Division of Drug and Alcohol Program Licensure for which separate consent will be obtained. I give permission to release patient and educational information to my Home Caregiver.
- I understand I may be contacted by UPMC by cellular phone, which may include the use of pre-recorded /artificial voice messages, and/or an automated dialing device (“auto dialer”) or by text message or e-mail in connection with any communication made to me or related to my accounts \_\_\_\_\_ **Patient Initials**
- I understand that my information may be released if required by local, state or federal law.



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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 payer and their agents to process payments. I also authorize UPMC to release any medical or other information required by my insurer, other payers and their agents. I also authorize UPMC to release medical or other information required by my insurer, other payers 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, and/or rehabilitation 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 payer 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.
7. If I make an application for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

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.

VIII. 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 Authorization/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 may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.).

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

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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 payer and their agents to process payments. I also authorize UPMC to release any medical or other information required by my insurer, other payers and their agents. I also authorize UPMC to release medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.
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