

CONSENT TO TREATMENT

I request those physicians and other health care professionals who care for me, to perform routine diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the physicians and facilities of AHN. Routine diagnostic procedures and medical treatments include but are not limited to x-rays, physical therapy, blood tests and administration of medications and other diagnostic monitoring measures. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I agree to have my photo taken for identification purposes. Where applicable to maternity cases, I acknowledge that a photograph of my newborn baby may be taken for security purposes.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the physicians and other health care professionals of AHN to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my hospitalization. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that AHN is an organized health care arrangement consisting of hospitals and primary and specialty care practices. Sharing my protected health information among its providers is essential for my care. I further understand that other community providers may also need to access my protected health information throughout AHN and with other community providers to allow for efficient care management and delivery.

By providing my phone number, I agree that the employees, agents, allied health professionals, contractors, or other representatives of AHN and its subsidiaries and affiliates, and/or any party contracted on their behalf, may contact me using automated dialing, pre-recorded script, interactive voice response, and/or text messaging technologies for health care related or account administration related communications, including but not limited to appointment and wellness reminders, results, or prescription refill notifications, care or benefit coordination activities, pre and post-operative or home health instructions, collection of financial liabilities owed, customer service or quality improvement operations, inquiries regarding participation in research studies, and/or for other non-telemarketing purposes. I understand that I may opt out of these types of communication methods without impacting my ability to receive care.

CONSENT TO TELEHEALTH ENCOUNTER

I understand that there are potential benefits of participating in telehealth, including care coordination, health management, and outcome improvement. If applicable, I hereby consent to a telehealth encounter for evaluation, diagnosis, and treatment. The telehealth encounter may occur with an off-site provider using two-way videoconferencing equipment, an online health questionnaire, secure messaging, or other approved electronic means to transmit my health data. I understand that information used during this encounter may include my medical records and images, audio and video recordings, and output data from devices. I acknowledge that I have the right and opportunity to ask questions about this process.

I am aware that laws protecting the privacy and security of my health information apply to telehealth. I further understand that information will be transmitted over a secure network, and if stored, will be saved in a data repository protected by security protocols. I acknowledge that information obtained or recorded during an encounter may become part of a designated record set, and I may request access to such information.

I acknowledge and accept that there may be risks associated with telehealth, including the quality of transmitted information, the ability to fully evaluate and diagnose certain conditions, delays in the encounter due to equipment limitations, and in rare cases, a security protocol failure. I acknowledge that alternative methods to telehealth may be presented to me if they are available, and I will have an opportunity to ask questions about such alternatives.

I acknowledge that I have the right to withdraw my consent to the use of telehealth and will be advised of any impact to my care, such as treatment delay or potential cost related to transfer.



**Consent to Treatment, Release
and Acknowledgment**

Patient Identification

RELEASE OF RESPONSIBILITY

I understand that if I leave the facilities of AHN without the consent of the physician and/or fail to carry out instructions for follow-up care, I am doing so of my own free will. I further understand that any injury or harm I may suffer while away from the facilities of AHN will be entirely my responsibility. I further release the physicians, other health care professional agents, servants, and employees of AHN from any claim by me or anyone on my behalf for the injuries or harm suffered while away from the facilities of AHN.

I understand that I am responsible for the security and whereabouts of any money, documents, personal items, or other articles of unusual value unless such valuables are deposited with the appropriate office/personnel for safekeeping. All clothing, eyeglasses, contact lenses, dentures, hearing aids, jewelry, cash, or other personal property that I wish to keep with me while I am at an appointment or receiving treatment is at my own risk as to loss or damage. I release the physicians, other health care professionals, agents, servants, and employees of AHN from any liability whatsoever for lost articles and money that I might keep with me.

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

If applicable, I permit AHN to maintain my records pertaining to treatment of substance use disorder protected by federal law in its electronic health system, Epic, and to share these records, including dates of service, name of treating provider(s), notes, and diagnosis, with my treating providers, health plans, third-party payers, and AHN personnel. I permit AHN to share these records for treatment, payment, and operations purposes as necessary. My consent to share these records will continue only as long as necessary for these stated purposes. I understand that if I revoke my consent to share these records, such revocation will not impact disclosures made in accordance with this consent prior to any revocation. I understand that records used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and no longer protected by federal law. I also understand that my failure to permit AHN to share these records will prevent AHN from being able to bill my insurance for these services.

CONSENT TO AMBIENT / RECORDING TECHNOLOGY

I permit AHN to use ambient listening technology and record me to aid in my care. Ambient listening technology improves clinical efficiency and allows my clinician to focus on my care instead of typing clinical notes. I understand that recording and ambient listening technologies, each or in combination, may be used to: create transcripts, assist in review and creation of medical documentation, analyze charts, assist with coding, create summaries, improve quality and efficiency, monitor facilities and patient rooms, and for other permissible purposes. I understand that I may discuss these technologies with my clinician and request information on how to opt-out of using ambient listening technology.

CONSENT TO APPEAL

In the event that my insurance company denies payment for any services rendered during this episode of care, I authorize the agents, servants, and employees of AHN to file a grievance for payment on my behalf; I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to AHN filing a grievance on my behalf, I understand that I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent shall automatically be rescinded, and I may file my own grievance if my health care provider does not file a grievance or stops grieving my case. I understand that I am not required to agree to such Consent to Appeal and may opt out without affecting my ability to receive services.



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STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians, other health care professionals or AHN for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIANS

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 Pennsylvania Department of Human Services (DHS), New York State Department of Health (DOH) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or hospital / facility services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Pennsylvania DHS or New York State DOH for payment.



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ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to physicians and AHN and any of its contract health care providers. I authorize physicians and AHN and the appropriate health care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable AHN, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to obtain the required pre-authorization. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

ACKNOWLEDGMENT OF RESPONSIBILITY FOR PAYMENT OF PHYSICIAN, HOSPITAL, FACILITY BILLS

I guarantee payment of all charges incurred for services rendered by the physicians, other health care professionals, and the facilities of AHN for the patient named on the opposite side of this page. The amount due for non-insurable charges including co-payment, deductibles, and private room fees shall all be paid in full at the time of service. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney’s fees and collection expenses.

DOCUMENTATION ACKNOWLEDGMENTS

I acknowledge that I have received and reviewed a copy of both the AHN Patient Rights & Responsibilities and the Notice of Privacy Practices (the “Notice”). I understand that information AHN acquires or creates about me will be disclosed to others for treatment, payment and health care operations or other appropriate purposes as set forth in the Notice or as authorized by me in writing.

CONSENT TO PROPER VENUE

I agree that any controversy, dispute, claim or lawsuit for damages arising out of or relating to my care and treatment by any provider or entity of Allegheny Health Network shall be litigated in the county where my care and treatment occurred.

**I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.
THIS CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGMENT FORM WILL REMAIN IN EFFECT FOR A
PERIOD OF ONE YEAR UNLESS I DECIDE TO REVOKE IT.**

Signature _____ Date _____ Time _____

Patient Substitute Decision Maker Verbal Consent (requires two witness signatures)

Signature of Witness _____ Date _____ Time _____

Signature of Witness (For Verbal Consent Only) _____ Date _____ Time _____

Substitute Decision Maker:

If a patient is unable to give valid consent, decision maker must print full name, state reason and relationship to the patient.



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