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

For the purposes of this consent, includes all physician offices providing healthcare services which are part of Great Lakes Physician Practice, PC dba: JAMA-GLPP

1. I,_____ (print or type name) on behalf of (patient name and relationship) _____ consent to the provision of treatment that may include diagnostic procedures or testing and medical treatment by Great Lakes Physician Practice, PC. (GLPP), that 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. If I have a religious objection to specific care to be provided I may ask GLPP not to provide such care.
2. 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 GLPP for education as well as health care operations purposes.
3. 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. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. If applicable, I give GLPP 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 GLPP and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows GLPP 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.
5. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

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.

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. **Patient Initials (required)** _____

I have been provided the Notice of Privacy Practices, either now or previously. **Patient Initials (required)** _____

FINANCIAL ARRANGMENTS

I agree to the following terms related to payment for services provided by GLPP and affiliates.

1. I authorize GLPP to bill my insurance carrier and request such payments to be made directly to GLPP. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to GLPP all rights to insurance payments or benefits to which I may be entitled for services provided to me by GLPP. I authorize GLPP 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 GLPP to release any medical or other information about GLPP 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 GLPP to release any medical or other information required by my insurer, other payers and their agents. I also authorize GLPP 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 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), GLPP is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

MINOR ABLE TO CONSENT FOR CARE (if applicable)

I am under 18 years of age and for the following reason(s)_____,
I am entitled 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 is valid for one (1) year from the date that I sign it and applies to all GLPP medical practices

This consent cannot be modified; any handwritten changes will not be legally binding or enforceable.

_____

Patient/representative signature **Date** **relationship**

Witness Signature **Date**