Cone Health (CH)

Hospitals and Outpatient Services

Patient Consent
Assignment of Insurance Benefits

Consent for Diagnosis and Treatment; Contractor Physicians Not Agents of Cone Health

I have a condition requiring health care and hereby consent to the provision of such care which may include diagnostic procedures, including HIV testing, and such treatment as the attending physician (s) and other Cone Health medical staff members may consider necessary. I understand that Cone Health is a teaching institution and I agree that students training to be physicians or other health professionals may observe or assist in providing my care and that my medical records may be used in connection with such training including students not directly involved in my care. I understand that some physicians (contractor Physicians) provide their services as independent contractors to Cone Health, are not employees or agents of Cone Health, and that Cone Health is not liable for their acts or omissions. Contractor Physicians include, without limitation, physicians with the following groups: Greensboro Radiology, P.A., Greensboro Anesthesia Physicians, P.C., Greensboro Pathology, LLC, Wake Forest University Health Sciences, Greensboro Radiation Oncologists, PA and Piedmont Neonatology, M.C. I decline HIV testing. ________

Patient Certification, Assignment of Insurance Benefits and Guaranty of Payment

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act or any other government or insurance benefits is correct. I authorize payment of hospital insurance, government or other third party benefits, including major medical, directly to Cone Health. I authorize payment of benefits directly to all treating and consulting Physicians and vendors.

I understand that I am financially responsible for, guarantee and agree to pay in full, in accordance with the regular rates and terms of Cone Health at the time of the patient's treatment, for all charges for all services provided to me by Cone Health, independent physicians, or other independent healthcare professionals involved in providing treatment or consultation to me at Cone Health, even if such treatment is not covered by insurance. I understand that my bill will be sent to the address on file unless I complete a request for my bill to be sent to an alternate address.

If I elect to pay my bill in full prior to receiving services, I can request that no protected health information regarding the services received and paid for by me be released to my health plan.

I authorize Cone Health and any independent practitioner (s) that have provided services to me at Cone Health to act on my behalf as attorney –in-fact with regard to: (1) collection of benefits from any responsible third party through whatever means necessary; and (2) endorsement of benefit checks made payable to me and/or Cone Health or such independent practitioner (s). If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including reasonable attorneys' fees.

I authorize payment of any refund that is due of any overpaid insurance benefits to be paid to the appropriate payer in accordance with my insurance policy conditions or any applicable benefit provisions where my coverages are subject to a coordination of benefits clause. With regard to any refund due to me, I authorize immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by Cone Health. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Consent for Release of Information for State Financial Assistance Programs

I authorize the Financial Counseling staff of Cone Health to represent and assist me in the processing of an application for benefits, including but not limited to Medical Assistance (Medicaid), TANF or Special Assistance, initiated by or on my behalf within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I or my representatives would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor orally via telephone, photocopy or telefacsimile. I authorize referral to the County Department of Social Services for benefits by use of an appropriate referral form, including but not limited to the DMA-5020.

 Patient Initials________ Date_____________

Please turn to next page

I request that the final disposition of my application for benefits, along with an explanation of any denial, be attached to and returned with the appropriate referral form.

Consent for Release of Medical Information

I understand that my medical information could include medical history or information regarding the first time or subsequent diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, etc.), mental illness, alcohol, drug or substance abuse or developmental disability. Cone Health, physicians and other health care professionals involved in providing my care at Cone Health are authorized to obtain and release such medical information (except psychotherapy notes)obtained or needed during this visit/registration for purpose of treatment, payment and health care operations as stated in the notice of privacy practices from and to the following specific persons, facilities or entities:

1) emergency transport services that transport me to or from Cone Health Facilities
2) groups or their agents identified above in the Assignment of Insurance Benefits section;
3) third party insurance, managed care, Medicare, Medicaid, workers compensation or other payors that I identify as possible payment of the services that have been provided to me;
4) persons or agencies who process applications for or determine my eligibility for financial benefits;
5) any person or external review agency involved in reviewing, authorizing or processing my eligibility for insurance coverage, benefits payment or billing compliance for potential payors that I identify;
6) physicians, pharmacies, facilities, agencies, etc. that refer me to Cone Health, or to whom I am referred, that represent that I have been referred to or have presented to them for treatment or medication or that are contacted concerning possible appropriate care for me during my stay or after discharge;
7) agencies of the North Carolina Department of Health and Human Services (DHHS). I may object in writing to on-site inspection of my medical record by agencies of DHHS and prohibit such inspection;
8) family or persons that I or my representative involve in my care unless specifically restricted by me;
9) county health care providers that are involved in my care or benefits, such as county Mental Health, Public Health and Social Service Departments.
10) Required government reporting, i.e. communicable disease, violent acts, etc.

I understand that HIPAA allows me to place certain restrictions on how my protected health information is used. **I will specify those restrictions on a HIPAA Restriction form.**

Release of Liability for Valuables:

Cone Health cannot assume liability for money or valuables taken to the patient's room/treatment area.

I understand that I may revoke my consent/authorization at any time by notifying Cone Health in writing, except to the extent actions have already been taken based upon my consent/authorization. Any Revocation will be effective one business day after the Cone Health Privacy Officer receives the written revocation. I understand and agree to the above releases, authorizations and assignments of benefits.

Signatures (Seal):____ Date:________________________

(Patient or Legal Guardian/POA. If patient is unable to sign)

Signatures (Seal):____ Date:_______________________

(Insured/guardian, if different from patient/legal guardian/POA)

Consent to Diagnosis and Treatment Obtained by Telephone

Treatment/Procedure:____

Authorized Person Giving Consent:____

Telephone # __________________________________ Relationship to Patient:____________________________

Witness:_________________ Witness:_________________ Date & Time: ____________________________