Master Acknowledgment | Consent Form

Patient Name: _____ Date of Birth: _____

Parent or Legal Guardian: _____

I as the patient, parent, or legal guardian consent or agree to the following *(initial next to all that apply)*:

____ **Assignment of Benefits:** I assign to and authorize payment of all insurance, and health care benefits available to the subscriber directly to IHA for services provided to the patient. I understand that benefits may be payable to the subscriber directly if I do not provide this authorization.

____ **Authorization to Share:** I have been given an opportunity to authorize another individual to be involved in my care.

____ **Consent to Treat a Minor (In Parent's Stead):** I have been offered an opportunity to have a third person representative to act on my behalf regarding the treatment of my minor child (in my stead).

____ **Consent to Treat:** The patient above is being treated at IHA, and I consent to all medical care, examinations and tests determined by the Physician to be necessary for the patient. I understand I have the right to decline services and testing, and I assume full responsibility and release IHA and the Physician relating to services and testing for which I decline. I do however, understand that financial assistance is available if I should need it. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

____ **Consent to Use of Information:** I understand that IHA may collaborate with other healthcare providers to coordinate, manage and provide health care to the patient. I consent to IHA sharing my health information and records electronically for the purpose of treatment, payment or health care operations including eligibility verification, insurance payers, state and federal programs, Workers' Compensation, quality improvement, compliance and health care oversight activities, POM ACO and Health Information Exchanges. This collaboration improves the overall quality care services to the patient. I understand that the electronic health record (EHR) includes sensitive diagnoses and related information such as HIV/AIDS, Sexually Transmitted Diseases, Genetic Information, Behavior Health and Substance Abuse, and Pregnancy and Prenatal Care. The electronic health record will be accessible by IHA/Trinity Health credentialed physicians and providers; Clinsite and Cancerlinq (research partners), Health Information Exchanges, Insurance or Government Innovative Care Models; other individuals approved to access the EHR for purposes related to treatment, payment and health care operations and/or other purposes permitted by HIPAA. As required by HIPAA, IHA has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and security of the Protected Health Information (PHI).

____ **Missed Appointment Policy:** I Acknowledge receipt of IHA's Missed Appointment Policy and agree to notify the office as soon as possible if unable to keep the scheduled appointment time.

____ **Notice of Privacy Practices:** I AGREE I have received or been offered a copy of IHA's Notice of Privacy Practices which provides information on how IHA may use or disclose PHI. I have been given an opportunity to opt-out of certain uses or disclosures of the patient's PHI if I choose to by completing an opt-out form.

____ **Patient Financial Obligation:** I AGREE I have received or been offered a copy of IHA's Patient Financial Obligation Policy. I understand that I am financially responsible for charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to the patient which are not eligible for payment (non-covered, i.e., co-insurance, deductible, copay, etc.).

Patient Signature: _____ Date Signed: _____

Parent or Legal Guardian Signature: _____ Date Signed: _____