**GLPP - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

**(TPO) IN NEW YORK**

*Imprint Patient Identification Here*

# GLPP, for the purposes of this consent, includes all physician offices and other locations providing healthcare services

**that are located in New York.**

**I. CONSENT TO TREATMENT This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.**

1. 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 abuse treatment, medical treatment and/or admission to 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 mental health and drug and alcohol abuse treatment facilities, this TPO will act as a consent for treatment only (and not for the release of information – that I must separately authorize). 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.

1. I understand and agree that others, under the direction of a physician, may assist or participate in providing medical care to

me for teaching purposes. These people may include but are not limited to residents, fellows, and medical/nursing students.

1. 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.
2. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.
3. I understand and agree that GLPP may at its discretion provide certain services to me by means called “telehealth”, all of which are covered by this authorization. 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 provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse treatment “telehealth” services.

1. When a physician orders home health, hospice or ancillary services they will be directed to a GLPP provider unless otherwise requested or

required by patient’s insurance. GLPP honors patient choice among providers of healthcare

**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**

1. I have been provided the GLPP Notice of Privacy Practices, either now or previously. **Patient Initials (required).**
2. I give GLPP and its designees permission to use my information as described in the GLPP Notice of Privacy Practices.
3. GLPP may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc. Such information may include sensitive information such as genetic testing information, abortion-related information, HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent permitted under state and federal law, GLPP (including its hospitals, staff, physicians and other entities and programs) may access and share my medical and other information as is necessary for GLPP to provide treatment to me, seek payment for services it provides, or for GLPP’s own healthcare-related operations. This includes my specific consent for GLPP to share mental health information (including, but not limited to, all information relating to my diagnosis, prognosis, treatment, care coordination or any other information contained in my patient record).
5. I understand that GLPP may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation, referral, and/or the provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent in order for GLPP to release certain types of sensitive information - including genetic testing information, abortion-related information, HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for GLPP to report any vaccine administered to me to the New York Department of Health and to release patient and educational information to my home caregiver.
6. I understand I may be contacted by GLPP 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**
7. I understand that my information may be released if required by local, state, or federal law.

**V. FINANCIAL ARRANGEMENTS**

# 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 also authorize GLPP to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I authorize GLPP to release medical or other information required by third parties, 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 and agree that any physician charges not paid by my insurance are my responsibility. I understand that final billing will be made upon determination of all charges incurred, less any payments actually received, and/or allowed adjustments from insurers contracted with GLPP. I understand that it is my responsibility to pay GLPP all charges so incurred as set forth in UPMC’s Charge Description Master (CDM). For more information regarding UPMC’s Charge Description Master please go to [https://www.upmc.com/patients-visitors/paying-bill/services.](http://www.upmc.com/patients-visitors/paying-bill/services)
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.

**VI. PATIENT VALUABLES**

I relieve GLPP 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 GLPP 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 THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED**

I agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in a County in which the care at

issue is provided.

**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 New York 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 GLPP facilities (such as physician practices, hospitals, clinics, etc.).

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| Patient Signature (Witness is required for verbal consent) | Date | Time | Signature | of | GLPP | Representative/Witness |
| Signature/Identify on behalf of patient/relationship Name | Date | Time | | | | |