Consent for Treatment and Payment Agreement

I hereby authorize Ohio Hills Health Services to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

Treatment includes but is not limited to the administration and performance of treatments and all tests deemed necessary to diagnosis and/or treat the particular conditions for which I have sought health care. The patient, parent or guardian retains the right to refuse any or all treatment/tests they deem unnecessary after consultation with the doctor/physician assistant/nurse practitioner.

I give my permission to Ohio Hills Health Services to release pertinent medical information concerning me to my insurance companies, if applicable, and authorize my insurance company to pay all benefits due, if any, directly to Ohio Hills Health Services or supplier for services rendered. Payment by the insurance company to Ohio Hills Health Services or supplier for services previously paid for by the patient or guardian at the time of service will be refunded to the patient, parent or guardian.

Healthcare operations include but are not limited to release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary, and I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full effect until revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original. If patient, parent or guardian refuses to sign this agreement, OHHS reserves the right not to render services.

Note: Insurance claims are filed as a courtesy to you without charge. However, Ohio Hills Health Services cannot accept the responsibility for collecting for your claim or negotiate a settlement on a disputed claim. Even though an insurance claim has been filed, all charges are the responsibility of the patient.

Patient Name ____DOB_______________

Signature____Date_______________
Patient/Parent/Guardian (circle)

Witness (OHHS personnel): _________________________________ Date_____________