5213212 - Consent for Care/Treatment - Use of Protected Health Information

I am receiving medical care from one or more of the following UHS Entities: United Health Services Hospitals, Inc., United Medical Associates, P.C., Chenango Memorial Hospital, Inc., Delaware Valley Hospital, Inc., Professional Home Care, Inc., Twin Tier Home Health, Inc. and its authorized employees and agents (hereinafter defined as "UHS Entities"), including its physicians and/or allied health professionals, such as nurse practitioners and physician assistants (collectively "UHS Providers"). I understand that I can directly, or through my representative, participate in selecting, and having final authority to choose, my physicians and other medical providers. I hereby voluntarily and of my own free will consent to UHS Entities providing me such medical care, including diagnostic procedures, and medical treatment, that they believe necessary and beneficial for me. I understand that the medical decisions that UHS Providers propose to me regarding my healthcare reflect their best independent medical judgments. I agree the medical services described by UHS Providers are appropriate for me.

This consent is valid at all UHS Entities' locations for one year from date of signature and may be revoked at any time in writing and won't affect any care prior to revocation. A list of UHS Entities' locations will be provided upon request. I acknowledge that no party, including UHS Providers or any other parties, guarantee me any specific outcome from any medical treatment that I receive from UHS Providers.

CONSENT TO USE PROTECTED HEALTH INFORMATION

I acknowledge receipt of and am able to request the UHS Entities Notice of Privacy Practices, (the "Notice") that informs me how UHS Entities may use and disclose my protected health information ("PHI"), including my address, phone number, e-mail address, and any other PHI for treatment, payment, or healthcare operations. I reviewed or was given the opportunity to review the Notice before signing this consent. The UHS Entities' Notice states that it may be changed from time to time and, if any UHS Entity does so, I may obtain a revised copy by contacting the UHS Privacy Office.

I can request that UHS Entities restrict use or disclosure of my PHI even for treatment, payment or health care operations. The UHS Entities are not required to agree to any of my requested restrictions to my PHI, but if they do, the UHS Entity is obligated to adhere to the agreed upon restricted access. Requests must be submitted in writing to the privacy office.

By signing this form, I consent to the UHS Entities using, receiving and disclosing my PHI for treatment, payment and health care operations (inclusive of reminder notices, healthcare education materials, and class registrations). I authorize UHS Entities to appeal any denials on my behalf. I authorize UHS Entities to obtain my current and previous medication history from my pharmacies. I acknowledge that my information may be used to contact me about potential research studies for which I may be eligible. I know that I may revoke this consent, in writing, to the privacy office, at any time, however, any such revocation will not apply to disclosures that any UHS Entity previously made.

I consent that UHS Entities and its business associates (Business associates are companies who are working with UHS Entities to meet its treatment, payment and healthcare operations needs and are held to the same privacy standards as UHS Entities) may contact me at any mailing address, e-mail, landline telephone number, wireless cellular telephone that I may provide, portal or other technology, to reach me. I consent to the use of automated dialing and announcing devices, playing recorded message and receiving text messages. I may receive electronic communications and if I no longer want to receive them, I will follow the discontinuation instructions for each communication.

I authorize UHS Entities to send and receive information about me between other Healthcare Facilities for the purpose of Healthcare treatment, payment and operations (Epic Care Everywhere). To opt out of this, please send written notification to the UHS Privacy office as listed below in the Contact Information section.

PATIENT FEEDBACK, CARE COORDINATION, AND INFORMATION

I authorize all UHS Entities and its representatives to contact me for my feedback regarding the medical services that I received. I understand that to assist the UHS Entities continuous effort to improve patient care, I may be contacted to provide my feedback specifically related to my medical condition and/or to the care that I received from the UHS Entity I attended. I also understand that as another component of the UHS Entities' continuous effort to improve care, the UHS Entities may disclose my name and medical condition to outside companies with which it contracts to collect patient feedback and provide care coordination. I hereby directly and specifically consent to that outside company accessing my PHI and contacting me (a) regarding my specific medical condition, (b) the care UHS Entities provide me and (c) my ongoing medical condition and issues, including advice regarding my continuing care. Any such company is required to maintain the confidentiality of my name and condition. I also understand that if I do not want to participate in this patient feedback process, I need to notify UHS Entities in writing at UHSH Patient Survey, 10-42 Mitchell Ave Binghamton, NY 13903.

To minimize outbreaks of some infectious diseases, immunizations may be administered. In order to ensure providers are aware of my current immunizations the New York State Immunization Information System will be capturing and transmitting immunization information across New York State.

PATIENT BILL OF RIGHTS

UHS Entities offered me or I otherwise received the Patient's Bill of Rights and Advance Directives.

_____ Patient / Representative Initials for Page 2 Review

ASSIGNMENT OF PAYER BENEFITS

I agree to allow UHS Entities, and its affiliates to be entitled to sufficient monies and/or benefits to which I may be entitled from government agencies, insurers or any other parties (collectively "Payers") financially liable to pay UHS Entities for any medical services that UHS Providers furnish me.

INSURANCE BENEFIT QUOTES

My Payers' promises to pay UHS Entities do not necessarily guarantee that UHS Entities will be paic by them. I understand that I ultimately am liable to speak and to confirm with my Payer those benefits to which I am entitled.

GUARANTEE OF PAYMENT

I understand that my Payer may not reimburse UHS Entities for certain medical services that I receive from UHS Entities and I fully understand that I ultimately am responsible for any amounts that my Payers will not pay UHS Entities. Further, I consent to UHS Entities having my credit analyzed should I ever owe UHS Entities what it determines to constitute substantial balances.

I hereby understand and agree that I am directly responsible to pay UHS Entities for any medical services that my Payer refuses to pay UHS Entities and I hereby guarantee that I shall pay UHS Entities for all of those medical services. A copy of the charge file is available upon request.

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that all information I provided upon applying for my Medicare benefits is accurate. I authorize UHS Entities to release any of my PHI to the Social Security Administration, the Centers for Medicare & Medicaid Services or to either of their intermediaries or carriers as needed for this or for related authorized benefits on my behalf. I assign all benefits payable for physician services to UHS Entities for furnishing me medical services and authorize UHS Entities to submit a claim to Medicare for payment on my behalf.

Physician Coverage Disclosure Notification: For hospitals with less than 15,000 unscheduled emergency visits per year, the supervising physician or attending physician need not be present but shall be available within 30 minutes. **Public Health Law 405.19 Emergency Services.** As a critical access hospital (CAH), Delaware valley Hospital provides 24-Hour Emergency care via on-site 24/7 mid-level coverage, 24/7 medical doctor/osteopathy on-call support within 30 minutes of contact.

Contact Information:	Privacy Office 10-42 Mitchell Avenue Binghamton, NY 13903	UHS Patient Survey 10-42 Mitchell Avenue Binghamton, NY 13903	1-888-383-7370
Payer Information:	UHS Business Office 346 Grand Ave Johnson City, NY 13790	UHS Business Office 33 Lewis Road Binghamton, NY 13903	

_____ Patient / Representative Initials for Page 3 Review

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Patient Consent:

By signing below, I reiterate my consent to the information and to the guidance described above.

Printed Patient Name:_____

Signature of Patient:_____ Date:_____ Time:_____

Witness Printed Name:_____

Witness Signature:_____ Date:_____ Time:_____

-Or- Patient Representative Consent:

Printed Name of Parent/Legal Guardian or Healthcare Agent Authorized to Give Consent:

_____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Healthcare Proxy ☐ Other: _____

Signature of Authorized Agent:_____ Date:_____ Time:_____

Witness Printed Name:_____

Witness Signature:_____ Date:_____ Time:_____

Physician Attestation of Patient Lack of Decision Making Capacity:
(If Patient, Parent, or Guardian is unable to consent, this must be completed by the physician)

I certify that I have examined the patient and determined, to a Reasonable Degree of Medical Certainty, that the patient lacks capacity at this time to make medical decisions due to:

☐ Unconscious ☐ Dementia ☐ Delerium/Confusion ☐ Other _____
☐ Mental Illness ☐ Developmental Disability

Attending Physician's Signature:_____ Date:_____ Time:_____