



GENERAL CONSENT FOR TREATMENT

I do hereby voluntarily agree and consent to authorize the administration and performance of all medical treatment and routine diagnostic procedures during my visit to a TriHealth facility. While being treated, I permit my doctor, the hospital and its employees, students in health care training programs and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that the practice of medicine and surgery is not an exact science and acknowledge no guarantees have been made to me as to the result of treatments or examinations in the hospital.

- I understand that radiologists, emergency physicians, pathologists, and anesthesiologists who practice at TriHealth hospitals are not employed, directed, or controlled by TriHealth or the facility. I understand that other physicians who render professional services to me at TriHealth facilities may be independent practitioners and may not be employees or agents of TriHealth or the facility. Neither TriHealth nor the facility is responsible for the acts or omissions of physicians that are not employed, directed or controlled by TriHealth or the facility.
I understand that Bethesda Hospital and Good Samaritan Hospital are related through a company known as TriHealth, Inc. These hospitals and other related providers have formed a network of health care providers known as the TriHealth Network. I agree that records concerning my condition and treatment may be kept or reviewed at locations within TriHealth other than the facility(ies) at which I am receiving treatment. Because of this, I agree that all medical or other information about me which has been acquired in the past by any provider in the TriHealth Network and any information relating to this admission/treatment may be released or disclosed, from time to time, to any other provider(s) in the TriHealth Network including any physician(s) who may be caring for me.
I understand TriHealth facilities are not responsible for the loss of or damages to my personal property unless it has been deposited in the hospital's safe. A safe is provided in the security office.
I agree to allow recordings and photographs of me to be made by employees, agents, contractors, and providers of a TriHealth facility for reasons including but not limited to assistance in diagnosis/treatment, teaching, research, documentation of conditions present on admission, and provider internal purposes.

I understand that, if I am a recurring patient, the above consent and authorization applies to all records and accounts generated and services rendered during and through the completion of my treatment plan.

The above has been fully explained to me, including the paragraph regarding the physicians' relationship with TriHealth and the facility, and I certify that I understand its contents.

X Patient Signature Witness Date

The patient is unable to consent because: Witness Date

I therefore consent for the patient: Signature Signature Relationship to Patient Witness Date

I received a copy of TriHealth's Notice of Privacy Practices and I acknowledge and agree to the terms in the Notice. Patient / Guardian Signature: X Date:

Staff: If the patient did not acknowledge receipt of Notice above, you must document below your efforts to obtain the patient's acknowledgment and the reason why it was not obtained:

HOSPITAL STAFF TO COMPLETE PATIENT RIGHTS AND RESPONSIBILITIES Patient given copy of the Rights which includes information about the complaint process. PATIENT WITH SPECIAL NEEDS Does the patient have a need for any special equipment or an interpreter? Staff Initials

Authorization for Review & Release of Information for Claim Determination, Payment and Other Purposes

In order to provide services to patients and increase efficiency, the Hospital often uses parties not related to TriHealth to perform a variety of tasks and services. The Hospital contracts with these third parties to assist in such tasks as:

- billing and collection of fees for all services provided to patients; and,
- conducting surveys and gathering information from patients regarding the quality of care and/or services they experienced while at the Hospital.

I (as patient or as agent of the patient) understand the above and hereby authorize TriHealth, Inc., its subsidiaries, and/or its subsidiaries' physician(s) providing services to me, to permit access to and/or release information contained in my medical record to third parties engaged by TriHealth, Inc. and/or its subsidiaries for the above services and others of that nature. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions.

Many insurance companies, employers and governmental agencies are requesting private (not affiliated with TriHealth, Inc.) agencies to review the medical care and medical records of our patients. Failure to consent to such a review or revocation of this consent may make the patient personally responsible for all charges incurred. The insured's employer may be participating in such review activities, and details of treatment may be reviewed by the insured's employer or their agent.

Federal law requires TriHealth, Inc. to inform you that if Medicare pays for any part of your health care bill, your medical record may be reviewed by a review organization. This review is to assure the government that services are medically necessary and meet recognized standards of quality. Redislosure of any of the above information requires separate written authorization. This authorization will expire upon receipt of final payment except where allowed by law or upon revocation of this release.

I (as patient or as agent of the patient) understand and hereby authorize TriHealth Inc., its subsidiaries, and/or physician(s) providing services to me, to permit access to and/or release medical information, including copies of such information, to Centers for Medicare and Medicaid Services and any other third parties applicable to the services rendered for the purposes of reviewing, establishing or verifying eligibility for hospital, ambulance, and/or physician(s) benefits and for the billing of hospital, ambulance and/or physician(s) services. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions.

I understand that, if I am a recurring patient, the above authorization applies to all records and accounts generated and services rendered during and through the completion of my treatment plan.

X _____
Signature of Patient/Guardian Date

Claim Payment Authorization

TriHealth, Inc., its subsidiaries, and some of the physicians providing services to you will initiate payment of your claims for benefits. In order to do this, it is necessary for all responsible parties to give TriHealth, Inc., its subsidiaries, and these physicians certain rights and permission. All patients are responsible to have knowledge of their insurance requirements and to convey the applicable requirements to TriHealth, Inc., its subsidiaries and their physicians.

I (as patient or as agent of the patient) hereby assign and transfer all rights of third party payer benefits for services rendered to me to TriHealth, Inc., its subsidiaries and/or physician(s), and authorize any insurance or third party payments to be made directly to TriHealth, Inc., its subsidiaries and/or the physician(s).

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under the terms of any other carrier is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services and any other services to the physician(s) or organizations furnishing the services and authorize such physicians(s) and/or organization(s) to submit a claim to Medicare or other third party payor for payment. Any assignment of benefits is limited to the Medicare allowed charge for physician services or to an amount not to exceed the hospital's regular charges.

I understand that in consideration of the services to be rendered, I may be responsible for payment for any services not covered by third party payors and I will pay any and all charges due and owing TriHealth, Inc., its subsidiaries, and/or any physician(s) in accordance with their regular rates, terms and policies.

I understand that, if I am a recurring patient, the above authorization applies to all accounts generated and services rendered during and through the completion of my treatment plan.

X _____
Signature of Patient/Guardian/Insured Date

Pursuant to Section 3727.42 of the Ohio Revised Code, you are entitled, upon request, to a copy of the Hospital's price information list which contains the usual and customary charges for room and board and the usual and customary charges for a select number of x-ray, laboratory, emergency room, operating room, delivery room, physical therapy, occupational therapy and respiratory therapy services. Call a TriHealth Financial Counselor at 513-282-7055 if you would like to obtain a copy of the Hospital's price information list.