Cosmetic Surgery
&
Rejuvenation Center

Patient Name ______________________ Date of Birth ______________ Sex ☐M ☐F

Address ____

City/ST/Zip ____

Primary Phone ______________________ Secondary Phone ______________________

General Consent

Consent to Treat I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, and other minor procedures) to be performed by employees, including but not limited to physicians, nurses, and assistants of TriHealth, Inc. and its subsidiaries (hereinafter "TriHealth").

I understand that Ohio law gives me the right to have an HIV test performed on me anonymously (my identity will be unknown) but that Ohio law does not require health care facilities to make anonymous HIV testing available. TriHealth does not provide anonymous HIV testing. By signing below, I acknowledge and agree that I am waiving my right to an anonymous test and that any HIV test ordered on me within TriHealth will be performed on a non-anonymous basis. In other words, my identity and test results will be maintained in my confidential TriHealth medical record and may be known to the healthcare providers who are treating me.

I understand that my protected health information will be used by TriHealth, as necessary, for my treatment, to obtain payment for this treatment, and for the health care operations of TriHealth. I also understand that my protected health information will be disclosed to other TriHealth affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment and for health care operations of TriHealth.

I understand that TriHealth will warn the appropriate authorities and/or other individuals if my TriHealth care giver determines that I am a harm to myself or to others.

I understand that if at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not limited to communications regarding appointment reminders, billings and payment for items and services, unless I notify TriHealth in writing. Such calls and text messages may be delivered via artificial or pre-recorded messages, automatic telephone dialing devices or other computer assisted technology, e-mail text messages, or by any other form of electronic communication from TriHealth, its affiliates, contractors, providers, or agents including collection agencies.

X ______________________________________ ______________________

Patient Signature Date/Time

More on reverse ▶

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Payment TriHealth will not bill any insurance company (including Medicare, Medicaid or commercial insurance) for any services provided in TriHealth Cosmetic Surgery and Rejuvenation Center. You acknowledge that you are responsible for payment and have read and agreed to our Procedure Payment Policy.

X ______________________________ ______________________

Patient Signature Date/Time

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that TriHealth give you a Notice of Privacy Practices that describes how TriHealth will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I have received a copy of the Notice of Privacy Practices.

X ______________________________ ______________________

Patient Signature Date/Time

Staff: If the patient did not sign the Acknowledgment of Receipt of the Notice above, you must document below your efforts to obtain the patient's acknowledgment and the reason why it was not obtained and scan the consent into the patient's electronic chart.

The staff member attempted to give the Notice to the patient but the patient did not sign the acknowledgment above because (complete below):

- ☐ Patient refused to sign
- ☐ Other reason (Staff: insert reason): ______________________________