



Ohio Plastic and Reconstructive Surgery LLC

112 Morey Dr. Marysville, OH 43040

GENERAL CONSENT FOR MEDICAL TREATMENT AND PERMISSION TO RELEASE INFORMATION FOR BILLING

I understand that I have the right to make informed decisions about my health care treatment. I agree to have the doctors and staff do tests and treatments they feel are needed for my care. These may include, but are not limited to vital signs, x-rays and imaging, lab tests, therapies, medicines and services utilizing Telehealth and video technology. I know other treatments or tests that have more risk will be explained to me so I can give informed consent for them if I need them. I know I can ask my doctor any questions I have about my treatment.

I agree to get text messages to the cell phone number I provide. The text may be from OhioPRS staff and others doing work for the health system. The text messages may be for appointment reminders, education, and other healthcare services or related to any lawful purpose. I know that none of my protected health information will be sent. I understand that data usage and other charges from my cellular provider may apply. I may stop text messages by replying STOP. If I do not agree to receive text messages, I know I can still get care from the health system.

I know there are rules I must follow when receiving care. I understand that the doctors and staff will help me know what the rules are. I agree to follow the rules for my safety and for the safety of others.

I know the hospital or doctor's office is not responsible for any of my belongings that I choose to keep with me. I agree that I should send any valuables and belongings I do not need home with my family or friends.

I ask my insurance or other payor to make direct payment to OhioPRS and my doctors for all services that are covered by my benefits. I know that I have to pay any unpaid amount for my care that is not covered or is considered out of network by my insurance or other payor. If I do not pay my bills, I know they will be sent to collections. I agree I will pay any collection fees and court costs from this process.

If I receive Medicare, I agree that the information given by me to apply for payment is correct. I have been given a paper listing my rights as a Medicare patient. I know I have the right to ask for a review of my record to find out about any payments I may owe if Medicare will no longer cover my stay.

If I receive Medicaid or Disability, I agree to have a person from OhioPRS or a company working for them act on my behalf in dealing with the State Department of Human Services. They may request a hearing or seek information from my file as the need arises.

Release of Information: I agree to have information about my care and treatment released, based on the law, to:

- My doctors and other providers who provide care to me;
- My insurance company and others who pay my bills for care;
- Companies that help collect payment for my care;
- Any government agency to which I have applied for aid;
- Any government agency which provides payment for my services;
- For administration and operations of OhioPRS.

If I have had treatment for alcohol or drug abuse, psychiatric issues, HIV or AIDS, that information may also be released.

I have read this and understand this form, or had this form read and explained to me. I sign this form as my consent.

Patient _____

Date _____ **Time** _____

Authorized Agent _____

Relationship to Patient _____

Witness (optional) _____