Tschetter & Hohm Clinic, P.C.

Patient Consent Form

Patient Name _____ Date of Birth _____

Receipt of Notice Of Privacy Practices:

I have received a copy of the "Notice of Privacy Practices" as required by HIPAA. I understand it is my responsibility to read and make myself aware of the contents of said notice.

Patient Signature_____ Date_____

Or

Patient's Representative Signature_____

Private Pay &/or Commercial Insurance:

1. I understand that I am financially responsible for all charges not covered by an authorized third party payer. This authorization will remain in effect until revoked by me in writing.
2. I hereby authorize direct payment for all medical and/or surgical benefits from Commercial Insurance Companies to be paid directly to Tschetter & Hohm Clinic, P.C. for all medical services provided by the Clinic's staff.
3. I hereby authorize the release of all information acquired in the course of my examination and treatment that is deemed necessary for filing my insurance claims.

Patient Signature_____ Date_____

Or

Patient's Representative Signature_____

Medicare (Lifetime Signature Authorization):

I request that payment under the medical insurance program be made either to me or to the Clinic named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above Clinic to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Authorization Period: From_____ To_____ (or until revoked/rescinded)

Patient Signature_____ Date_____

Medigap (i.e. Supplemental Insurance):

I request that payment under the medical insurance program be made either to me or to the Clinic named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above Clinic to release to the Medigap Company any information needed for this claim or any related Medigap claim. I further permit a copy of this authorization to be used in place of the original.

Patient Signature_____ Date_____

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Obtain External Prescription History:

I authorize Tschetter & Hohm Clinic, P.C. to view my external prescription history via our electronic health record system. I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here at Tschetter & Hohm Clinic, P.C., and may include prescriptions back in time for several years. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information, such as medication names or dosages.

Patient Signature_____ Date_____

Or

Patient's Representative Signature_____

Promoting Interoperability: (THC encourages Patients to NOT Opt-Out)

I understand the Clinic uses Commonwell Health Alliance or Carequality to send and receive protected health information to other medical providers that are also using these organizations. This information is ONLY being shared with other medical providers that the patient has seen or will be seeing in the future.

If you do not want to have your medical information shared with other providers seen by you, please circle the following Opt-Out option: Opt-Out

Sign and date: _____ _____

Patient Signature Date

OR

Patient's Representative Signature_____

My signatures on this Patient Consent Form certifies that I have read and understood the scope of my consent to the above items.