Greenville Hospital System
University Medical Group*
Consent for Treatment

The following are the conditions for services provided by Greenville Hospital System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Hospital System University Medical Group or GHS UMG for the patient whose name appears below.

Medical Consent

I consent to all treatment given under the general and special instructions of the attending physician(s). Treatment may include, but is not limited to, diagnostic procedures, administration of anesthetics, use of prescribed medication, medical and physical therapy services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician or their designees.

If a health care worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker (in accordance with South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of the testing will be made available to the patient.

Assignment of Insurance Benefits and Third Party Claims

If the account is not paid at time of service, I hereby assign to GHS UMG the proceeds from the following: TRICARE medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health, accident or welfare benefits of any type or form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by or on behalf of a third party; and any other benefits due from the insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid, or other benefits. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect, and that I have the right to make this assignment. In the event a claim for payment submitted by GHS UMG to my insurance carrier or plan administrator is denied, I hereby authorize GHS UMG to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. Section 8901 et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management.

Financial Agreement

I understand that, if my insurance plan or policy requires a co-payment from me, I am required to pay that co-payment at the time service is rendered. I understand that, if I am self-funded, full payment is due at time of service. I understand that I am obligated to pay the patient account according the regular rates and terms of GHS UMG. I appoint GHS UMG as my true and lawful attorney to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, the payment will be posted to the intended account and the refund processed accordingly. I understand that GHS UMG may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will pay all collection fees and reasonable attorney's fees.

Medicare Patients

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS UMG on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

Disclosure/Use of Health Information

I authorize GHS UMG to provide any health information related to this patient to the insurance company or other payor, for purposes of payment for the health care provided. I also authorize GHS UMG to provide health information to other physicians and healthcare facilities for continuing care. I further agree that GHS UMG can use the health information for operations such as peer review and outcomes analysis. I acknowledge that I have received a copy of the GHS UMG Notice of Privacy Practices.

[ ] **(Patient initial here to acknowledge that Privacy Notice was received.)**

I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as a part of GHS UMG and may be enforced under the practice name, provider name or as GHS UMG.

Patient Photographs

I understand that a facial photograph may be taken at the first visit and periodically thereafter for identification purposes only and that it will be part of my medical record and will be subject to all the protection that other personal health information receives.

Patient Name (PRINT)________________________________ DOB ____________

Patient/Personal Representative Signature: ________________________________ Date: ____________

PRINT Name and Relationship if Personal Representative: ________________________________

GHS UMG Representative Name: ________________________________ Date: ____________

**University Medical Group is the faculty practice plan of Greenville Hospital System.*

12-16-08