KANSAS UNIVERSITY PHYSICIANS, INC., d.b.a. The University of Kansas Physicians (UKP) CONSENT FOR Treatment, Payment and Health Care Operations (TPO)

I, _____ (print or type name) on behalf of _____ (patient name and relationship) consent to treatment by UKP and its affiliated physicians and employees. Treatment may include routine diagnostic procedures and medical treatment. Treatment may also include photographs and video and audio recordings which may be used for my care and/ or educational purposes. I understand that I may have the opportunity to participate in the consent process except in an emergency. I also understand that I will be asked to sign separate consent forms for any non-routine procedures and treatments. I agree that no guarantees or promises have been made about the result of any exam or treatment.

I understand that UKP is affiliated with the University of Kansas Medical Center which has teaching responsibilities. I authorize other providers, under the direction of a physician or other faculty member, to assist and participate in providing my care. These individuals include, but are not limited to, residents, fellows, and medical, nursing, and allied health students. I give my consent that all tissues and specimens obtained, which would otherwise be discarded, may be used for research and/or teaching purposes when they do not identify me as the patient. I also understand that I may be asked to sign additional and separate authorization forms for clinical research and research using tissue specimens that identify me as the patient. I give UKP and its designees permission to use my information as described in the Notice of Privacy Practices for KU Medical Center including medical records that may include psychiatric history and alcohol or drug abuse information.

Financial Arrangements

I agree to the following related to payment for services provided by UKP and its affiliates:

1. I authorize UKP to bill my insurance carrier and request payments be made directly to UKP. I certify that the information I gave about my insurance coverage or other payment sources is correct.
2. I assign to UKP all rights to insurance payments or benefits that I may be entitled to for services provided to me by UKP and its affiliates. I authorize UKP to act on my behalf and as my representative to request reconsideration by my managed care plan or utilization review committee for coverage or grievance review.
3. I authorize UKP to release any medical or other information about UKP services or services provided by third parties if needed for payment. This information may be released to third parties, including my insurer, other payors and their agents, and government agencies or their designees.
4. I assign all rights to benefits, insurance proceeds or other payments or judgments that I may be entitled for hospital-based physician services, outpatient-based services, and office-based services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
5. I accept full financial responsibility for services received by the patient which are not covered by government benefits or any type of insurance. I agree to pay for any services not covered by insurance or government benefits. I understand that possession of medical insurance does not relieve me of my financial responsibility to UKP. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.
6. If I chose to pay for certain services out of pocket and exercise my right to limit release about those services to my payor, I understand that a separate financial agreement will be put into place regarding self-pay services and this section will not apply to those services.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND AM AUTHORIZED TO CONSENT FOR MEDICAL CARE OF THE PATIENT NAMED BELOW.

Patient's Name: _____ UKP Acct #/MRN _____

Signature of Patient or Authorizing Person: Signature of Witness

_____Date: _____ _____Date: _____

_____ _____

Relationship to Patient Clinic

Authorization must be signed by the patient, by a parent if the patient is a minor, or by a guardian if the patient is incapacitated.