

**THE CHRIST HOSPITAL PHYSICIANS**  
**PATIENT REGISTRATION AND CONSENT**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

1. **CONSENT TO TREATMENT:** I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/ or testing as considered necessary for my condition as directed by my physician(s) (or advanced practice provider) and his/her associates or assistants as may be needed. I understand and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my physician (s) in the performance of medical, surgical or diagnostic procedures/treatment that my physician (s) consider necessary.
2. **RELEASE AND USE OF RECORDS:** I authorize the release of medical records information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I authorize the release of medical record information to the physician(s) or agency responsible for my follow-up care, and/or to the healthcare facility to which I am transferred from TCHP. I authorize TCHP to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with TCHP's system. I authorize release of my medical record information as required or permitted by state or federal law including, but not limited to, for purposes of obtaining payment.
3. **COMMUNICATING WITH YOU:** Consent to contact by electronic and other means. The Christ Hospital Physicians, its employees, its affiliates and subsidiaries and its affiliates and subsidiaries' vendors, agents, successors, and assigns (collectively, TCHP), may contact me for any lawful reason, including for the collection of amounts owed to TCH and for the offering of products or services in compliance with applicable privacy policies and requirements that are in effect from time to time. No such contact will be deemed unsolicited. By signing below, I authorize and voluntarily consent to TCHP contacting me: (i) at any address (including e-mail) or telephone number (including wireless cellular telephone or ported landline telephone number) that I provide, have provided, or that was provided on my behalf to TCHP; (ii) using any means of communication (including, but not limited to, postal mail, electronic mail, telephone, text, messaging or other technology) to reach me; and (iii) using automated dialing systems and announcing devices and playing recorded messages.

I understand that I may contact TCHP's HIM/Medical Records Department to ask that TCHP not contact me using any one or more methods or technologies by writing to us at 2139 Auburn Ave Cincinnati, OH 45219, calling us at 513-263-8660 or by any other reasonable means. I understand that my receipt of healthcare treatment and services is not conditioned upon my agreement to this provision.

4. **FINANCIAL AGREEMENT:**
  - a. **Assistance.** I understand that TCHP has Patient Financial Services Counselors (513-585-2302) available to patients who request help in understanding their insurance and their financial responsibility to TCHP; who seek cost estimates; and/or who want to determine their eligibility for financial assistance or government healthcare.
  - b. I understand that TCHP has established standard charges for services and items provided during my care. These standard charges are maintained in a charge list or chargemaster and are updated from time to time.
  - c. I understand and agree that in consideration of the services to be rendered to me/the patient, I/patient guarantee payment of the account and will promptly pay the full amount of the hospital bill and any physician charges in accordance with the charge list or chargemaster rates and terms
  - d. I understand that it is my responsibility to understand the terms of my insurance or health plan including the terms or limits of coverage and whether my physician or advanced practice provider is in network.
  - e. **In-Network.** If TCHP currently has a contract with my/patient's commercial health plan that covers my/patient's medical care at TCHP, I hereby authorize TCHP to submit a claim to the health plan for medical care and items TCHP provides, and, at TCHP's option, to take legal steps to obtain payment from the health plan for all medical care and items on my behalf. I understand and agree that I am responsible to pay directly to TCHP any deductible, co-payment, cost-share, coinsurance, or other patient payment responsibility as determined by my health plan.
  - f. **Out-of-Network.** If TCHP does not have a contract with my/patient's commercial health plan that covers my/patient's care at TCHP, I hereby authorize TCHP to submit a claim to the health plan for medical care and items TCHP provides, and, at TCHP's option, to take legal steps to obtain payment from the health plan for all medical care and items on my behalf. I understand that my health plan may determine that it is not responsible to pay for all or part my care, and, in that case, I agree I am responsible to promptly pay for my care at TCHP, in the amount of the TCH's total charges for my/patient's medical care, calculated in accordance with TCH's charge list or chargemaster in effect at the time of care, unless TCHP and I enter into a different written, executed payment agreement. I understand and agree that I am responsible to pay directly to TCH any deductible, co-payment, cost share, and coinsurance or other payment responsibility as determined by my health plan.



- g. **Non-Covered Services.** I understand that even if I am an eligible member of a commercial health plan, the plan may determine prior to, concurrent with, or after TCHP provides a service or item to me that one or more service or item is not a covered benefit under my health care benefit plan. If my health plan determines that a service or item provided by TCHP to me is not a covered benefit under my health care benefit plan, I hereby authorize TCHP to pursue payment from me for the non-covered service or item of amounts up to TCHP's total charges, calculated in accordance with the charge list or chargemaster in effect at the time of care.
- h. **Medicare/Medicaid.** I understand that I am responsible to pay directly to TCHP any cost share or co-payment due from me under these government programs, as well as any charges for treatment or services or item not covered by these programs that I have requested and agreed, in advance, to be provided. I understand that Medicare and Medicaid are payers of last resort and TCH may choose not to bill those payer sources if a third party is liable to pay for his/her treatment.
- i. **Coordination of Benefits.** I understand that my commercial health plan may ask if I have other insurance to coordinate benefits (COB), and I agree to promptly reply to this question from my commercial health plan and TCHP. I understand that a COB denial from my health plan will result in my responsibility for the total charges.
- j. **Assignment of Benefits.** I hereby authorize payment directly to TCHP and/or my physician(s) and/or their designees, all Medicare benefits, other insurance benefits, or other payments from any payer liable by reason of contract or negligent or wrongful conduct, otherwise payable to me
- k. Nothing in this agreement shall preclude TCHP from seeking reimbursement from other responsible third parties (e.g., health plans, auto and liability insurers, third party administrators, and government healthcare programs) for any amounts that may be due from them. I authorize TCHP to apply any credit balances to balances owed to The Christ Hospital.
- l. I agree to release TCH from any responsibility or liability arising from the loss or damage to personal items or valuables brought to TCHP.

5. OTHER PATIENT RESPONSIBILITIES:

- a. **Safety.** TCHP has zero-tolerance for violence and abusive language or behavior. We are committed to maintaining a safe environment that is free from threats and acts of intimidation and violence. As such, it is the expectation of TCHP that you and your visitors will conduct yourselves in a respectful, non-violent and non-abusive manner. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities.
- b. **Past Due Accounts.** Payment is due upon receipt of the statement and your account is considered past due if not paid within 28 days of the statement date. If your account becomes severely past due, we will take necessary steps to collect the debt, including placing the account with a collection agency.
- c. **Missed Appointments.** It is important for you to keep your appointments. If you cannot keep your appointment we request you notify us within 24 hours of the appointment so we can adjust our schedules. Missed appointments where we are not given 24 hours' notice may be charged \$50.00, payable prior to your next scheduled appointment.
- d. **Dismissal.** I understand that my failure to comply with my responsibilities above may result in my dismissal from the TCHP.

I confirm that I have read and agree to the preceding information and received a copy of this form. Any questions that I may have had have been answered fully and to my satisfaction. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Patient's Signature: \_\_\_\_\_ Date & Time: \_\_\_\_\_

Patient is unable to consent because: \_\_\_\_\_

or  
 Patient is unable to consent because he/she is a minor: \_\_\_\_\_ (indicate years of age)

Closest Relative or Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_