Tallahassee Cancer Institute

1653 Mahan Center Blvd., Tallahassee, FL 32308
Tel: (850) 219-8000 • Fax: (850) 219-8003

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

CONSENT TO MEDICAL CARE

I, _____ **(Print or type name)** consent to the provision of care that may include diagnostic procedures, Medical treatment and/or admission to the Tallahassee Cancer Institute, which my attending physician or his/her authorized agent may consider necessary or advisable. I understand that this care may include tests (including diagnostic images), examinations, medical treatment, taking photographs (including video recordings) and making audio recordings that may be used for internal medical and educational purposes. I understand that a separate consent form will be required when taking such photographs or recordings for external purposes such as commercial filming, television programs of marketing. If have a religious objection to specific care to be provided, which may include taking photographs and making audio recordings, I may ask Tallahassee Cancer Institute to not provide such care. I understand that special consent forms may need to be signed for some procedures involving entry into the body. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential. Oral consent requires two witness signatures.

I also understand and agree that others, under the direction of the physician involved in my care, may assist or participate in providing hospital and/or medical care at those Tallahassee Cancer Institute teaching facilities. This may include, but not be limited to, residents, fellows and medical/nursing students.

I give Tallahassee Cancer Institute and its designee permission to (1) use my medical information as described in the Tallahassee Cancer Institute Notice of Privacy Practices (Notice) and (2) when applicable, dispose of, by appropriate means, any specimens and tissues (such as blood samples and other fluids, PAP smears, skin tags, etc). Once disposed of, these specimens and tissues cannot be retrieved.

I understand that Tallahassee Cancer Institute and its designees may use such specimens or tissues, without my authorization (1) as part of its educational activities and programs and (2) for research purposes if the specimens or tissues are de-identified and used in accordance with applicable state and federal regulations. If the specimens or tissues are not de-identified, Tallahassee Cancer Institute shall not use them for research without my written authorization.

I have read this Consent to Medical Care section or have had it read to me, and it has been explained to my satisfaction.

Patient Signature	Date	Signature of Tallahassee Cancer Institute Representative
Signature/Identity on behalf of patient/relationship Name	Date	Signature of Tallahassee Cancer Institute Representative

TPO – FINANCIAL ARRANGEMENTS/RELEASE OF INFORMATION

I agree to the following terms of payment for services provided. Information related to mental health and drug and alcohol treatment requires specific consent (see #6 below).

1a. I authorize Tallahassee Cancer Institute to bill my insurance carrier and request such payments to be made directly to Tallahassee Cancer Institute. I certify that the information I have given about my insurance coverage or other payment sources is correct.

1b. I assign to Tallahassee Cancer Institute all rights to insurance payments or benefits to which I may be entitled for services provided to me by Tallahassee Cancer Institute. I authorize Tallahassee Cancer Institute to act on my behalf and as my representative to request reconsideration by my managed care plan or utilization review entity for both internal and external coverage or grievance review.

1c. I authorize Tallahassee Cancer Institute to release any medical or other information about this hospital stay, services provided by Tallahassee Cancer Institute, or services provided by third parties, if required to obtain payment from my insurer or other payor and their agents. I also authorize Tallahassee Cancer Institute to release any medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided.

2. I assign all rights of benefits, insurance proceeds or other payments or judgments to which I may be entitled for physician services for interpretation of laboratory, pathology, radiology, neurology, cardiology, diagnostic test, anesthesiology, and/or emergency room services to the physician or organization providing the service. I also authorized submission of a claim for payment on my behalf to my insurance carrier.

3. I consent to access by any Tallahassee Cancer Institute affiliate (including Tallahassee Cancer Institute hospitals, staff, physicians providing services to me and other entities and programs) to medical or other information maintained on electronic information systems or stored in various forms at individual Tallahassee Cancer Institute affiliates related to treatment and/or services provided to me by Tallahassee Cancer Institute or any affiliate in connection with my care, health care operations or payment for treatment and services. I also authorize information related to my care to be provided to my primary care/family physician (s) and as otherwise necessary for referrals, consultation, treatment and/or other treatment related health care services to me.

4. I have been provided the Tallahassee Cancer Institute Notice of Privacy Practices document. I also understand that additional copies of this Notice are available for my review upon request.

5. I understand that my information may be released if required by local, state or federal law.

_____ **Patient Initials (required)**

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6. **Sensitive Information (When Applicable).** I consent to and authorize the release of my sensitive medical or other information (for example : mental health and drug and alcohol treatment) to my insurance carrier (s) _____ for billing purposes, to other payors and to government agencies of their designees for review of the care provided. Additionally, with respect to any drug and alcohol related information, disclosure of such information about me shall be restricted to whether or not I am in treatment, my prognosis, the program structure treatment model and services offered to me, a brief description of my progress and a short statement as to whether I have relapsed into drug and alcohol abuse and the frequency of any such relapses. I understand that I have the right to revoke this consent at any time by notifying the Tallahassee Cancer Institute entity where I had provided such consent.

7. I understand that any amounts not paid by my insurance are my responsibility.

_____ **Patient Signature (required)**

MEDICARE CERTIFICATION

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries of carriers, any information needed for this of any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me.

MEDICAID CERTIFICATION

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, of concealment of material facts, may be prosecuted under applicable federal and state laws.
Acknowledgment of receipt – my signature acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS)/CHAMPVA and does not waive any of my rights to request a review.

PATIENT VALUABLES

I relieve Tallahassee Cancer Institute of any responsibility for loss of clothing, money, valuables, dentures, glasses, of any other items that I decide to keep with me while I am a patient. I further understand that Tallahassee Cancer Institute will not be responsible and will not replace any property lost, broken, of stolen, which I decide to keep with me, or any property brought to me while I am a patient.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____,
I am entitled under Florida Law to consent to medical, dental or other health services for myself , and if applicable, for my minor children without the consent of any other person,

____ **Patient Initials (required if completing this section)**

I have read this TPO-Financial Arrangements/Release of information section of have it read to me, and it has been explained to my satisfaction.

Patient Signature	Date	Signature of Tallahassee Cancer Institute Representative
Signature/Identity on behalf of patient/relationship Name	Date	Signature of Tallahassee Cancer Institute Representative

FOR OFFICE USE ONLY

Patient Name_____
☐ Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices _____
Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:
☐ Previously Received ☐ Refused ☐ Other: _____
Episode of Care : _____