Leaders in Rheumatology Care since 1955.

COLUMBUS ARTHRITIS CENTER
GENERAL CONSENT

Patient Name:____

Date of Birth: ______________________

Home Address: _________________________ ________________ _____ ________
Street and Unit City State Zip Code

Primary Phone Number: ______________________

Provider: ____

I am requesting that health care services be provided to me (or my minor child or the patient named above) at Columbus Arthritis Center ("CAC"). I voluntarily consent to all medical treatment and health care related services that the caregivers at CAC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that I have the right to discuss any treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I further understand that if I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I understand that my protected health information may be used or disclosed by CAC for my treatment, to obtain payment for this treatment, for its health care operations and in accordance with CAC's Notice of Privacy Practices. I also understand that my protected health information will be disclosed to other CAC affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment, and for its health care operations, and I consent to the practices contained in this section.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between CAC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CAC for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below;

OR Subject to applicable law and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CAC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CAC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CAC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CAC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CAC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CAC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CAC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

________________________________ ________________________________

Name of Signatory **Relationship to Patient (if Applicable)**

____ __________

Signature of Patient (18 years old or older) or Legal Guardian **Date/Time**

Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA requires that CAC give you a Notice of Privacy Practices that describes how CAC will use and disclose your protected health information and explains your HIPAA Privacy Rights.

I have read the Notice of Privacy at www.columbusarthritis.com under the "FORMS" tab or received a copy of the Notice of Privacy Practices.

____ __________

Signature of Patient (18 years old or older) or Legal Guardian **Date**