SEVEN HILLS
Women's Health Centers

Patient 4 in 1 Consent Form (Acknowledgement of HIPAA, Disclosure PHI, Assignment of Benefits, and Methods of Communications)

I have received Seven Hills Notice of Privacy Practices. ☒_____ Initials of Patient / Responsible Party

Patient **refused a copy** of the Seven Hills Women's Health Centers Privacy Practices. ☒_____ Employee's initials

GW # _____ (Print Patient's Name)

I _____, hereby consent for Seven Hills Women's Health Centers ("Seven Hills") to use and disclose my protected health information ("PHI") in the following manners:

(☑ Select any or all options)

☐ Seven Hills has my permission to leave me **Confidential Voice Messages** at my phone number listed below.
Patient phone #_____ ☒_____Initials of Patient / Responsible Party

☐ Seven Hills has my permission to discuss my **BILLING** information with the person listed below.
Name/relationship_____ ☒_____ Initials of Patient / Responsible Party

☐ Seven Hills has my permission to discuss my **MEDICAL** information with the person listed below.
Name/relationship_____ ☒_____ Initials of Patient / Responsible Party

☐ Seven Hills has my permission to release my **Test Results** to my Primary Care physician, when requested.
Physician name_____ ☒_____ Initials of Patient / Responsible Party

☐ Seven Hills has my consent to **display personal photos which I have provided**, these may include my minor children, first/last name, date of birth, height, weight, grade level or any other information I have provided relative to the photo(s). Seven Hills will not use these photos for marketing purposes. Seven Hills will only use photo for display purposes which I understand will be visible to the staff, patients, and visitors to Seven Hills. Seven Hills assumes no risk due to the display of my photo(s).
☒_____ Initials of Patient / Responsible Party

OPT-IN for Communications

"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events." ☒_____ Initials of Patient

I understand that this signed consent <u>does not have an expiration date</u> and that I may revoke this consent at any time with a completion of a new 4 in 1 consent form <u>or</u> I submit in writing my request to revoke my current 4 in1 consent on file. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request in writing to the Privacy Officer, 2060 Reading Road, Suite 150, Cincinnati, OH 45202. I also understand that this consent does not deny Seven Hills the right of using or disclosing PHI as described in any section of the Notice of Privacy Practices.

_____	_____	_____
Patient Signature	Print Name	Date
_____	_____	_____
Responsible Party Signature	Print Name & Relationship to Patient	Date

I hereby assign all medical and/or surgical benefits to which I am entitled including private insurance and other health benefit plans to Seven Hills Women's Health Centers. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize assignee to release all information necessary to secure payment.
MEDICARE PATIENTS: I request that payment of medical benefits be made to Seven Hills Women's Health Centers for any service furnished to me. I authorize release to CMS and its agency any medical information about me needed to determine these benefits.
MINOR PATIENTS: Parent signature may be required to accept financial responsibility.

_____	_____	_____
Patient Signature	Print Name	Date
_____	_____	_____
Responsible Party Signature	Print Name & Relationship to Patient	Date