Consent to Treat/Bill & Privacy Information Form

Thank you for choosing Reno Heart Institute for your health care. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

CONSENT FOR TREATMENT

By signing this form, I consent to and authorize my provider(s) at Reno Heart Institute (RHI) to treat me or my dependent. I understand this could include lab tests, x-rays/imaging, medication prescription and/or administration, education, or other diagnostic tests. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect as long as I am a patient of Reno Heart Institute.

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Reno Heart Institute to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical, dental, and/or behavioral health information to my insurers as necessary for determination and payment of benefits; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY

RHI complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the RHI Notice of Privacy Practices.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT

I authorize Reno Heart Institute to file a claim with my insurance carrier for services rendered. I authorize RHI payment of benefits directly to RHI, for services provided to my dependent or me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.

** If you are uninsured, please note that your account is your responsibility. No patient will be denied services due to his/her inability to pay. Discounts for essential services are offered dependent on income and household size as compared to the current federal poverty guidelines. Please inquire for more details. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account.**

HEALTH INFORMATION EXCHANGES

RHI endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to share patients' clinical information electronically, securely, and efficiently with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who participate in an HIE including but not limited to EPIC CARE EVERYWHERE, CERNER or other EMR systems of providers / institutions treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures.

LIMITS OF CONFIDENTIALITY

We are permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization: Emergency or urgent care or court order/subpoena.

I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent. I agree that a copy of this consent may be used in place of the original. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me.

My signature below indicates that I understand and accept the content of this form.

Signature ____ Date _______________________

Patient or Patient Representative (print name)____

If not the patient: Relationship to Patient: ____