Tulane University – Consent and Release

SCOPE OF POLICY

This policy applies to Tulane University Medical Group, its participating physicians and clinicians, and all University employees and business units who provide management, administrative, financial, legal, and operational support to or on behalf of Tulane University Medical Group and have been designated as part of the Tulane University HIPAA Health Care Component. This policy pertains to protected health information covered by Tulane University Medical Group’s Notice of Privacy Practices.

STATEMENT OF POLICY

This policy requires Tulane University Medical Group patients to sign a Consent and Release form before receiving care (new patient, one-time only) and prohibits billing audits on the records of any patient who has not signed either the form or a billing authorization.

IMPLEMENTATION OF POLICY

All patients must sign the attached Consent and Release form before receiving care at any Tulane University Medical Group clinic or by any Tulane University Medical Group practitioner, including care at Tulane University Hospital and Clinic. The Tulane University Hospital and Clinic form alone is not sufficient.

If a patient has not signed the Consent and Release form, no insurer, auditor, or other party may perform a billing audit on that patient’s records unless the insurer, auditor, or other party has obtained a billing authorization that includes:

1. the name of the payer, and if applicable, the name of the audit firm that is to receive the information;
2. the name of the institution that is to release the information;
3. the full name, birth date, and address of the patient whose records are to be released;
4. the extent or nature of the information to be released, with inclusive dates of treatment; and
5. the provider’s patient account number; and
6. the signature of the patient or his legal representative and the date the consent is signed.

08/2015
The TUMG Billing Office must confirm for the audit representative that a Consent and Release is available for the particular audit that needs scheduling. The TUMG Billing Office will also inform the requestor if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedures affecting the review.

Tulane University Medical Group’s HIPAA policies do not prohibit or restrict the ability of an insurance company or its auditor to review patient records as necessary to determine the extent of the insurer’s responsibility for a claim submitted by Tulane University Medical Group.

VIOLATIONS

The Privacy Official has general responsibility for implementation of this policy. Employees who violate this policy will be subject to disciplinary action up to and including termination of employment. Anyone who knows or has reason to believe that another person has violated this policy should report the matter promptly to his or her supervisor or the Privacy Official. All reported matters will be investigated, and, where appropriate, steps will be taken to remedy the situation. Where possible, every effort will be made to handle the reported matter confidentially. Any attempt to retaliate against a person for reporting a violation of this policy will itself be considered a violation of this policy that may result in disciplinary action up to and including termination of employment.
Tulane University Medical Group

CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties’ responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney’s fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULLY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman’s compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information.

PATIENT NAME

DATE OF BIRTH

PATIENT SIGNATURE

NAME OF AUTHORIZED-AGENT, IF ANY

SIGNATURE - IF SIGNED BY AUTHORIZED-AGENT

RELATIONSHIP TO PATIENT

WITNESS NAME

WITNESS SIGNATURE

DATE OF SIGNING

TIME

CONSENT FOR TREATMENT

DATE

TIME

I, OR FOR KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS

SIGNATURE

(PATIENT OR PERSON AUTHORIZED TO CONSENT

RELATIONSHIP)

DATE

TIME

REFUSAL OF CONSENT FOR TREATMENT

I

REFUSE TO CONSENT TO

UPON

I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS

SIGNATURE

(PATIENT OR PERSON AUTHORIZED TO CONSENT

RELATIONSHIP)
Tulane University Medical Group

CONSENTIMIENTO Y LIBERACIÓN

**ASIGNACIÓN DE BENEFICIOS:** Por la presente autorizo el pago directo a Tulane University Medical Group (TUMG), a todos los beneficios médicos, arreglos finales o sentencias aplicables a mi tratamiento a cargo de los médicos de TUMG y otros médicos del hospital o la clínica. Esta autorización, a menos que sea revocada por mí, es aplicable a todos los cargos y honorarios incurridos desde el día de la fecha en adelante. Entiendo que tengo la responsabilidad personal de pagar todos los honorarios aplicables a mi tratamiento a cargo de los médicos de TUMG del hospital o la clínica, incluyendo copagos, deducibles y honorarios por servicios no cubiertos, independientemente de otra cobertura de seguro o responsabilidad de otras partes hacia mi por tales honorarios. Si los saldos impagos estuvieran vencidos y fueran derivados para su cobro, acuerdo pagar honorarios de abogados, costos de la corte y/u honorarios de agencias de cobro asociados con dichos saldos impagos.

**LIBERACIÓN DE INFORMACIÓN:** Autorizo a TUMG y/o a sus médicos y otros clínicos a revelar todos o parte de mis registros médicos o de facturación, a cualquier compañía de seguros o personas empleadas por dicha compañía con el propósito de cobrar beneficios de seguros y auditar reclamos, siempre que yo figure en esa cuenta como persona cubierta por tal compañía de seguros. Esta autorización incluye la liberación y entrega de información a planes de salud grupales para coberturas de seguros grupales, compañías aseguradoras de compensación al trabajador y agencias de prestaciones sociales, si fueran aplicables a mi reclamo de tratamiento. Por la presente indemnizo y libero a TUMG y a sus médicos y clínicos de cualquier y toda responsabilidad relacionada con la liberación de tal información.

<table>
<thead>
<tr>
<th>NOMBRE DEL PACIENTE</th>
<th>FECHA DE NACIMIENTO</th>
<th>FIRMA DEL PACIENTE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NOMBRE DEL AGENTE AUTORIZADO SI CORRESPONDE</th>
<th>FIRMA (SI QUIEN FIRMA ES EL AGENTE AUTORIZADO)</th>
<th>RELACIÓN CON EL PACIENTE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NOMBRE DEL TESTIGO</th>
<th>FIRMA DEL TESTIGO</th>
<th>FECHA DE LA FIRMA</th>
</tr>
</thead>
</table>

**CONSENTIMIENTO PARA EL TRATAMIENTO**

YO, O PARA ___________________________ SABIENDO QUE ESTOY/ESTÁ PADECiendo UNA CONDICIÓN QUE REQUIERE DIAGNÓSTICO Y/O TRATAMIENTO MÉDICO O QUIRÚRGICO, POR LA PRESENTE DOY MI CONSENTIMIENTO VOLUNTARIO PARA LA EJECUCIÓN DE TALES PROCEDIMIENTOS DE DIAGNÓSTICO Y ATENCIÓN HOSPITALARIA, MÉDICA Y QUIRÚRGICA SEGÚN SE CONSIDEREN NECESARIOS A JUICIO DE LOS MÉDICOS A CARGO. ENTIENDO QUE LA PRÁCTICA DE LA MEDICINA Y LA CIRUGÍA NO SON CIENCIAS EXACTAS Y RECONOZCO QUE NO SE ME HAN DADO GARANTÍAS SOBRE LOS RESULTADOS DEL EXAMEN O TRATAMIENTO. POR LA PRESENTE AUTORIZO AL GRUPO MÉDICO DE LA UNIVERSIDAD DE TULANE A RETENER O DISPONER DE CUALQUIER ESPECIMEN O TEJIDO TOMADO DE MI CUERPO DURANTE EL TRATAMIENTO Y A UTILIZAR TALES ESPECIMENES O TEJIDOS PARA PROPÓSITOS CIENTÍFICOS, EDUCATIVOS O DE INVESTIGACIÓN, EN LA MEDIDA EN QUE TALES ESPECIMENES Y TEJIDOS NO SE CONSERVEN EN EL HOSPITAL O LA CLÍNICA DE LA UNIVERSIDAD DE TULANE.

TESTIGO ___________________________ FIRMA __________________
(PACIENTE O PERSONA AUTORIZADA A DAR EL CONSENTIMIENTO RE:ACCIÓN)

**FECHA ___________________________ HORA __________________**

**RECHAZO DEL CONSENTIMIENTO PARA EL TRATAMIENTO**

YO ___________________________ ME NIEGO A DAR EL CONSENTIMIENTO PARA ___________________________ DEBIDO A ___________________________

SE ME HA AVISADO ACERCA DE LAS CONSECUENCIAS Y RIESGOS DE ESTE RECHAZO Y POR LA PRESENTE LIBERO A LOS MÉDICOS, CLÍNICOS Y AL GRUPO MÉDICO DE LA UNIVERSIDAD DE TULANE DE TODA RESPONSABILIDAD SOBRE LESIONES SURGIDAS DE TAL RECHAZO.

TESTIGO ___________________________ FIRMA __________________
(PACIENTE O PERSONA AUTORIZADA A DAR EL CONSENTIMIENTO RE:ACCIÓN)

**FECHA ___________________________ HORA __________________**