Persons Served Agreement

Please Read Carefully

I consent to care and treatment.
I consent to examination, treatment, and testing as advised by the physicians and other providers of OVP HEALTH CARE. I consent to the use or disclosure of my protected health information by OVP HEALTH CARE to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business. I understand I may receive a call or survey from OVP HEALTH CARE asking about my satisfaction with my care and services.

I further consent to any treatment and testing by OVP HEALTH CARE, such as laboratory testing, that may be performed at the request of my medical provider. I understand my email address, if provided, may be used for surveys, and will be used to receive an invite to OVP HEALTH CARE patient portal. I agree to the terms and conditions set forth in this Persons Served Agreement, including the agreement to pay for the cost of care.

I have received the Notice of Privacy Practices.
I have received the Notice of Privacy Practices of OVP HEALTH CARE, which tells me how my health information may be used and shared. I understand that OVP HEALTH CARE reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

I agree that payments can be made directly to OVP HEALTH CARE.
I allow OVP HEALTH CARE to directly bill and collect payment from my insurance company, Medicare, Medicaid or other person or entity that pays my medical bills. I assign my right to receive payment of any insurance to OVP HEALTH CARE, including Medicare, Medicaid, or other benefits payable from any source. Some insurance companies will not pay for services unless they authorize the service in advance. I understand it is my responsibility to inform OVP HEALTH CARE if my insurance policy requires such authorization (sometimes called a prior authorization).

I agree to pay for the cost of care.
Based on the posted sliding fee schedule, I accept full responsibility for the cost of all services that OVP HEALTH CARE provides to me. I promise to personally pay all expenses and charges that are not paid by my insurance company or anyone else, but only to the extent OVP HEALTH CARE legally may bill me for such expenses and charges.

I can cancel this agreement.
I understand I can revoke this agreement in writing. This can be done at any time by delivering to OVP HEALTH CARE a written statement or revocation, except to the extent that OVP HEALTH CARE has acted in reliance on this consent, agreement, and authorization. I will be financially responsible for any medical services provided before the date of such revocation.

I agree to Telemedicine/Distance Counseling services.
I agree there may be times my provider may need to see me via telemedicine/distance counseling. I understand this will only happen if I have the proper technology. I also agree to use a secure location when utilizing the technology.

I have received the most recent OVP HEALTH CARE Handbook and can request another copy at any time.

I agree to follow-up calls.
I give my consent for OVP HEALTH CARE and its employees to contact me via telephone for any purpose related to my care.
I agree for OVP HEALTH CARE to leave messages on my phone. ___YES ___NO

I have read this form and I fully consent to what I am agreeing. *(The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations, and financial responsibility discussed above.)*

_____ _____
Date Signature of Patient or Legal Representative

STATEMENT OF PERSONS SERVED LEGAL REPRESENTATIVE OR AGENT
I give the consents and authorizations made above on behalf of the persons served, and I have the authority to do so. The person served did not sign because he or she is (check one)
____ A Minor (under 28 years old) ____ Mentally or physically unable to sign ____ Other: _____

I am authorized to sign for the persons served because: (parent/medical power of attorney, etc.)
_____