## 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. I consent to the use or disclosure of my protected health information by OVP HEALTH to diagnose and treat my, 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 asking about my satisfaction with my care and services.

I further consent to any treatment and testing by OVP HEALTH, 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 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, which tells me how my health information may be used and shared. I understand that OVP HEALTH reserves the right to revise the noticed 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.**

I allow OVP HEALTH 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, 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 if my insurance policy requires such authorization (sometimes called a prior authorization).

**I agree to pay for the cost of care.**

I accept full responsibility for the cost of all services that OVP HEALTH 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 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 OV HEALTH a written statement or revocation, except to the extent that OVP HEALTH 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 telemed/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 Handbook and can request another copy at any time.**

**I agree to follow-up calls.**

I give my consent for OVP HEALTH and its employees my contact me via telephone for any purpose related to my care. I agree for OVP HEALTH 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 persons served did not sign because he or she is (check one)

___A Minor (under 18 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)

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