Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Town and Country Pediatrics and Family Medicine, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) Please refer to Town and Country Pediatrics and Family Medicine. PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Town and Country Pediatrics and Family Medicine, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Town and Country Pediatrics and Family Medicine, PC, Privacy Officer at 380 Main Street, Watertown, CT 06795.

With my consent, Town and Country Pediatrics and Family Medicine, PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assisting practice in carrying out TPO, such as appointment reminder, insurance item and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Town and Country Pediatrics and Family Medicine, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and ConfidentiaL

With my consent, Town and Country Pediatrics and Family Medicine, PC may Email to my home or other designated location an item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Town and Country Pediatrics and Family Medicine, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request, but if it does, it is bound by the agreement.

By signing this form, I am consenting to Town and Country Pediatrics and Family Medicine, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Town and Country Pediatrics and Family Medicine, PC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that Town and Country Pediatrics and Family Medicine, PC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:
Privacy Officer Manager at **860-274-8891**

I also understand that I am entitled to receive updates upon request if Town and Country Pediatrics and Family Medicine, PC amends or changes its Notice of Privacy Practices in a material way.

Signature of Parent or Patient Representative: _____ Date:_____
_____

Printed name of patient or patient's representative: _____

Relationship to patient: _____

Everything below this line is for OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY Town and Country Pediatrics and Family Medicine, PC
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other(specify):_____

_____ _____
Name and title of employee Date

MEDICAL AUTHORIZATION FORM

I, _____, being the parent and/or legal guardian of _____ (hereinafter, my child(ren)) do hereby authorize _____to seek and obtain medical care for my child(ren) in the event that my child(ren) need{s) medical care.

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this authorization.

_____ _____

Name of Parent and/or Legal Guardian Signature of Parent and/or Legal Guardian

Date __

Please list your preferred provider: _____

Patient Name: Last _____First_____Middle___

Patient Date of Birth: _____Marital Status:_____

PatientAddress:_____City: _____ State: ___Zip: _____

Email Address for Patient Portal (If desired) :_____

Home Phone: _____ Can we leave a message? *Yes/No*

Work Phone:_____ Can we *leave* a message? Yes/No

Cell Phone: _____ Can we leave a message? Yes/No

Occupation: _____Place of Employment:_____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN PARENT):
NAME: _____ PHONE NUMBER: _____

PREFERRED PHARMACY: _____

It is recommended by the National Committee on Quality Assurance that we ask you the following information so that we can provide you with better care:

Preferred Language: (circle one) ENGLISH OTHER DECLINE

Race: (Circle one) CAUCASIAN BLACK ASIAN NATIVE- AMERICAN P ACIFIC-ISLANDER DECLINE

Ethnicity: (Circle one) HISPANIC NON-HISPANIC DECLINE

Visual Impairments? Yes/No Hearing Impairment? Yes/No

Patient insurance (Name of insurance company):_____

Patient insurance policy number:_____

Patient insurance group number:_____

Subscriber name:_____

Subscriber D.O.B:_____

Subscriber relationship to patient:_____

Secondary Insurance (Name of insurance company):_____

Secondary insurance policy number: _____

Secondary insurance group number:_____

Subscriber name:_____

Subscriber D.O.B:_____

Subscriber relationship to patient:_____

The following section below is for pediatric patients only:

MOTHER'S NAME: _____

MOTHER'S DOB: _____

ADDRESS: _____

CITY: _____
ZIP:

CAN WE LEAVE A MESSAGE?

Home Phone: Y/N

Work Phone: Y/N

Cell Phone: Y/N

Occupation: Y/N

Place of Employment: _____

FATHER'S NAME: _____

FATHER'S DOB: _____

ADDRESS: _____

CITY: _____

ZIP: _____

CAN WE LEAVE A MESSAGE?

Home Phone: Y/N

Work Phone: Y/N

Cell Phone: Y/N

Occupation: Y/N

PLACE OF EMPLOYMENT: _____

NAMES OF SIBLINGS AND DATE OF BIRTH:

_____

_____

_____

FOR ALL PATIENTS, PLEASE REVIEW AND SIGN BELOW:

ResponsibilitY for payment:

I acknowledge and understand that the patient's insurance may not *cover* all costs and expenses relating to the treatment and services the patient receives, and that certain services may *have* a co- payment or may not be covered by the patient's insurance plan. [also acknowledge that additional costs related to certain after-hours of Sunday appointments may not be covered by insurance, and that I may have responsibility for additional payments for those appointments. I specifically agree to be responsible for any amount not paid by the insurance or any amount(s) not paid due to failure to follow the procedures required to be performed by me (or the patient) per the insurance plan. I agree to make such payments within 45 days from billing by the practice, and in the event the account is not paid in full within that time, I will reimburse the practice for all costs of collection. Including reasonable attorney fees together with the interest charges.

SIGNATURE OF PATIENT/PARENT IF MINOR: _____ DATE: _____

Authorization and release:

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor Insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf.

SIGNATURE OF PATIENT/PARENT IF MINOR: _____ DATE: _____