

**Physician Services of Northeast Connecticut, LLC.**  
**Permission to Share Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

One of our goals is to protect your rights to privacy; therefore, unless we have your permission, information will not be given to anyone regarding you or your child's condition.

May we call you at work?  YES  NO

May we call you at home?  YES  NO

\*If no to both questions, do you have an alternative number (i.e. cell phone)? \_\_\_\_\_

May we leave messages (including laboratory results or other diagnostic tests) on your answering machine?  YES  NO

May we speak with your spouse or significant other regarding your personal health information?  YES  NO

Is there another person we may release you or your child's personal health information to? We will only provide information to those listed below.  YES  NO

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

May we send you a fax?  YES Fax#: \_\_\_\_\_  NO

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# Written Acknowledgement of Receipt of Notice of Privacy Practices

TO BE COMPLETED BY PATIENT OR PATIENT  
REPRESENTATIVE

Patient Type: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Written Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the hospital's Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact:

Privacy Officer  
860-928-6541, extension 2276

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

TO BE COMPLETED BY STAFF IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT  
FROM PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

Patient Type: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

On , \_\_\_\_\_ I attempted to obtain a Written Acknowledgement of Receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgement

Other (Specify): \_\_\_\_\_

\_\_\_\_\_  
Name and title of employee

\_\_\_\_\_  
Date

**PHYSICIAN SERVICES OF NORTHEAST CONNECTICUT, LLC.**

**AUTHORIZATION FOR BASIC TREATMENT**

**Name:** \_\_\_\_\_

**MR #:** \_\_\_\_\_

**INTRODUCTION:**

This is an agreement between you and Physician Services of Northeast Connecticut, LLC. (PSNEC). It contains your agreement to pay for all services you will receive from PSNEC. It also addresses the use of your medical records (and other information about "you", "your"), insurance benefits, and certain conditions in regard to your treatment. In consideration of receiving services, you agree as follows:

**AUTHORIZATION TO PROVIDE BASIC TREATMENT AND CONDUCT BASIC AND ROUTINE DIAGNOSTIC PROCEDURES:**

I authorize the performing of all routine examinations, treatments, and care provided to me under the general or specific instructions or direction of my physician.

Pursuant to Public Act 09-133, I understand that as part of the medical procedures or tests, I may be tested for HIV. I understand that HIV testing is voluntary and I can choose not to be tested for HIV or antibodies to HIV.

**INFORMED CONSENT:**

I understand that if I require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency my own physician will discuss the risks, benefits, and alternatives and answer my questions. I am entitled to consent or refuse to consent.

**RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:**

I authorize PSNEC to provide from its records any information and medical records including psychiatric, substance abuse, HIV related or other confidential information ("Confidential Information") requested by my insurance/managed care company, Medicare, Medicaid, Champus, or other third party payors, hospital agents or governmental agencies in connection with payment of my bill. I also authorize PSNEC and its agents to provide Confidential Information from my medical records to any utilization, managed care, and/or quality review organization affiliated with my insurer/payor or otherwise for use in utilization management. I further authorize PSNEC to provide Confidential Information to its case management personnel, including authorization to discuss my medical care with my physicians, and to other health providers and facilities involved in my continuing care. I also authorize the release of Confidential Information to state or federal agencies for authorized purposes.

I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future treatment except where disclosure of the communication and record is necessary for treatment. I understand that if my refusal to provide authorization results in a refusal of my insurer, managed care company or the third party payor to pay PSNEC, I will personally be responsible for the bill or the unpaid portion of the bill.

**ASSIGNMENT OF BENEFITS:**

I authorize third party payors, including insurers, managed care companies, and Medicare or Medicaid and other governmental payors, to make payment directly to PSNEC. I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account. I understand that my refusal to grant authorization to my third party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment, but understand that under such circumstances I will be responsible for paying my bill in full. Upon request, patients may receive copies of their charges.

**CONSENT TO RELEASE OF SOCIAL SECURITY NUMBER TO TRACK MEDICAL DEVICES:**

If in the course of my treatment I receive a medical device(s) that is traceable to its manufacturer, I authorize the release of my Social Security number to the manufacturer or its agent. I understand that PSNEC has been told that my Social Security number may be used by the manufacturer to attempt to locate me if necessary in regard to this medical device.

**PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES:**

The PSNEC's Policy on Patient Rights and Responsibilities has been provided to me, and I agree to comply with such policy.

**FINANCIAL AGREEMENT:**

I understand I am responsible for payment of any charges and agree to pay PSNEC the regular rates or charges for all medical services rendered to me. If I am covered by a third party (for example, Blue Cross & Blue Shield or other insurance or managed care, or a benefit program such as Medicare or Medicaid), then the third party may pay all or a part of PSNEC rates or charges. If so, I agree to pay those rates or charges that are not covered or paid by that third party, and to the extent permitted by law are properly payable by me, as soon as I receive a bill. If I do not pay my bill I agree to pay PSNEC any collection costs including attorney's fees, collection agency fees, and court costs. PSNEC reserves the right to accept periodic installment payments without waiving its rights to demand payment in full.

**MEDICARE AND OTHER GOVERNMENTAL PROGRAMS:**

I agree that the information I have given in applying for benefits under Medicare, Medicaid, Maternal or Child Health Services or other governmental programs is complete and accurate. PSNEC may give the appropriate state and/or federal agencies (including but not limited to, the State Department of Social Services and the federal Social Security Administration or its fiscal intermediaries), any information about me that I have that may be necessary to process claims for such payment. PSNEC doctors and allied health care providers treating me may make direct claims for payment.

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I HAVE READ THIS PATIENT AGREEMENT, OR IT HAS BEEN READ TO ME, AND I UNDERSTAND IT, ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I FREELY AGREE TO ALL OF THE TERMS AND CONDITIONS IN THE AGREEMENT THAT ARE APPLICABLE TO THE PATIENT EXCEPT THOSE SPECIFICALLY NOTED ABOVE BY ME AS NOT APPLYING.

\_\_\_\_\_  
**DATE:**

X

\_\_\_\_\_  
**SIGNATURE OF PATIENT**

\_\_\_\_\_  
**PRINT PATIENT NAME:**

\_\_\_\_\_  
**SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE**

\_\_\_\_\_  
**RELATIONSHIP**

If a representative has signed for the patient, please state the relationship to the patient and the reason the patient did not sign:

\_\_\_\_\_  
Reason