

## **PATIENT CONSENT & ASSIGNMENT FORM**

### **I. Consent to Treatment**

I authorize Plastic & Hand Surgical Associates, Skin Solutions from Plastic & Hand and Western Avenue Day Surgery Center which is a division of Plastic & Hand Surgical Associates collectively referred to as Plastic & Hand, its health care practitioners, staff, ambulatory surgical facility and other individuals involved in my care **to examine me and perform any tests, procedures and/or treatments that may be helpful to care for my injury or illness.**

I understand that Plastic & Hand is dedicated to teaching, that authorized trainees may observe and assist in diagnosis, treatment and care, and that photographs may be taken for purposes of diagnosis, teaching and documentation. I reserve the right to give specific permission for publication of any picture that personally identifies me.

### **II. Payment and Financial Obligation**

I request that **payment of authorized Medicare and/or other insurance company benefits be made either to me or on my behalf to Plastic & Hand** for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9d of the HCFA-1500 Medicare form is completed (secondary carrier after Medicare), my signature authorizes release of the information to the insurer or agency shown. In Medicare and/or other insurance company assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare and/or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare and/or other insurance company.

I understand that I am responsible for paying all charges associated with this treatment. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I am also responsible for those charges not covered by my insurance such as deductibles, co-pays or evaluations or treatment that are not included as an insurance benefit. I understand that if my insurance plan requires a referral, prior authorization for surgery and/or a second surgical opinion and this has not been obtained, I am responsible for payment of services rendered.

I authorize my health insurance carrier(s) or other third parties who are responsible for paying for my health care to pay costs associated with my evaluation and care directly to Plastic & Hand Surgical Associates.

I authorize the release of any medical information necessary to process this claim; I also request payment of benefits to Plastic & Hand. I realize that in the event these claims are denied by Workers' Compensation, I am responsible for payment, and I authorize my private health insurance carrier to reimburse Plastic & Hand in the event that Workers' Compensation denies payment. I understand that in order to be in compliance with Title 39 MRSA 52-A (2), Plastic & Hand must furnish my employer with periodic medical reports. I authorize release of information with the State M-1 form.

**III. CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I consent to Plastic & Hand Surgical Associates, Skin Solutions from Plastic & Hand and Western Avenue Day Surgery Center which is a division of Plastic & Hand Surgical Associates collectively referred to as Plastic & Hand, its health care practitioners, staff, ambulatory surgical facility and other individuals use and disclosure of my **protected health information** ("PHI") in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.

I consent to Plastic & Hand's **disclosure of PHI to other health care practitioners** and facilities that are involved in providing my medical services to me and to my family and close friends who are providing me with emotional support as I receive medical services. Also, I consent to Plastic & Hand's disclosure of PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

I understand that Plastic & Hand's **agreement to provide medical services to me** is conditioned upon my signing of this consent and that Plastic & Hand requests my consent to ensure that Plastic & Hand can properly carry out the professional responsibility of caring for me.

I understand that Plastic & Hand **will disclose only the minimum** amount of my health care information which is necessary, in the judgment of Plastic & Hand, for the legitimate needs of the recipient or for my general well being.

My PHI which is the subject of this consent includes demographic information, information about my physical or mental health or condition, information about the medical services provided to me (including payment information) if any of that information may be used to identify me. [Depending upon the medical services I request or require, this information may include information about treatment for HIV/AIDS, sexually-transmitted diseases, mental health or psychiatric conditions, or substance abuse.]

I understand that **I have a right to restrict Plastic & Hand's use and disclosure of my PHI** and that Plastic & Hand is not obligated to agree to the requested restriction, but that an agreement to a restriction binds Plastic & Hand. **I may revoke** this consent at any time by providing Plastic & Hand with a written, signed, and dated request except to the extent that Plastic & Hand has acted in reliance upon my consent. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

I understand that Plastic & Hand regards the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with Plastic & Hand.

I have received a copy of Plastic & Hand's **Notice of Privacy Practices** that provides a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice of Privacy Practices before signing this consent. I acknowledge that Plastic & Hand reserves the right to amend the Notice of Privacy Practices periodically. I understand that **I may obtain a current copy** of the Notice by contacting the office staff at any time.

From time to time our practice markets, sells or promotes products and services which we believe would be beneficial to our patients via mail and/or e-mail.

Yes, I would like to receive your periodic mailings.  No, I do not wish to receive any mailings

I understand that if I have any questions about this consent or about Plastic & Hand's privacy practices, or if I wish to have a copy of this consent, I may ask the office staff or my physician.

X \_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
PLEASE PRINT PATIENT NAME