Hartford Hospital Neurosciences – Headache Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ________________________________

E-mail address: ____

1) I have been offered or received a copy of Hartford HealthCare's "Notice of Privacy Practices."

2) I give my permission for Hartford Hospital to contact me at the following numbers and to leave a message on my answering machine or voicemail (if none, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone: _______________________ ☐Work ☐Home ☐Mobile

MESSAGES CONCERNING MEDICAL INFORMATION Phone: _______________________ ☐Work ☐Home ☐Mobile
(For example lab or test results)

If I provided a mobile telephone number during registration, then I hereby authorize Hartford Hospital and its employees, agents, and business associates, to contact me via such mobile phone for any reason, including without limitation, automated notifications and appointment reminders.

I give my permission for HHC Medical Group to communicate with the following persons regarding my health care:

Name: ___________________________ **Phone #:**________________ **Relationship:** ______________

Name: ___________________________ **Phone #:**________________ **Relationship:** ______________

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of Hartford Hospital.

3) **Assignment of Benefits**: I authorize direct payments to Hartford Hospital or its designated billing agent for services rendered.

Guarantee of Payment/Precertification By Insurer: I will be responsible for payment for all non-covered services. If my health plan does not consider Hartford Hospital to be a participating provider, I will accept full financial responsibility for payment of incurred charges. I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent for Treatment: I do voluntarily consent to the rendering of such care as the provider and/or medical personnel deem necessary for my health and wellbeing. This consent shall include medical examination and diagnostic testing as well as minor surgical procedures OR I may receive a practice specific consent form. The form may also include the carrying out of orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

4) To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across Hartford Hospital and some other HHC affiliated practices (accessed only as described in the Notice of Privacy Practices). Our current EMR does not functionally allow us to limit access to your record by blocking it from our Medical Group staff and related practices.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, the authorized health care providers and professionals listed at *https://hartfordhealthcare.org/terms-privacy-policy/joint-notice-of-privacy-practices*. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when Hartford Hospital's EMR no longer exists.

Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

☐ By checking this box, I choose to **opt out** and by doing so understand I **decline** to receive care at Hartford Hospital.

____ ________________________________

Patient Signature / Date **Parent or Guardian Signature / Date**

If patient is a minor (under age of 18) or has a guardian/conservator, this must be signed by the parent or legal guardian.