PRIVACY NOTICE AND CONSENT TO TREAT/DISCLOSE HEALTH INFORMATION

1. Consent to Treat: I consent to and authorize Emerson Hospital (EH) and physicians, assistants and consultants providing services at EH to render care, including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be in their judgment, necessary to care for me. I understand that absent emergency or extraordinary circumstances, major diagnostic and therapeutic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and the risks associated there with to my complete satisfaction with my physician or other health care professional. I acknowledge that I may be required to sign additional consent forms for certain specific medical treatments or procedures. I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic procedure or treatment performed on me while at EH and that medical care may involve risk of injury.

2. Release of Information: I acknowledge that it is the policy of EH that patient health information is confidential and shall not be disclosed unless permitted or required by law or I have specifically authorized the disclosure in writing. I authorize EH to release my health information: (i) to physicians and other health care practitioners on the EH Medical Staff who are involved in my health care now and in the future; (ii) to other health care providers, entities and institutions for the purpose of my continued care and treatment, including referrals; and (iii) as necessary for the health care operations of EH. I also authorize EH to release my health information to my insurance company, HMO, or other third−party payers, as necessary to bill and receive payment for my care. I recognize that information released for the purposes described in this paragraph may include sensitive information such as alcohol/drug abuse treatment and mental health, and I authorized the release of such information as necessary.

3. Assignment of Insurance Benefits: I authorize and assign to EH and the physicians, assistants and consultants providing care to me at EH the right to all insurance or other third−party benefits (otherwise payable to me) to which I am entitled for my treatment at EH. I understand that physician charges for professional services performed or supervised by a physician may be billed separately by the physician performing the services. I understand that I am responsible for providing EH with information necessary to allow EH and its physicians to bill my insurance. I understand I am financially responsible for payment of any charges by EH or its physicians that are not paid by insurance or other third party including if I have no insurance or coverage is denied. I further understand that EH does not accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim, and that I am responsible for the timely payment of my account(s).

4. Notice of Privacy Practice Acknowledgement: I understand that EH’s Notice of Privacy Practices" as required by federal law provides detailed information about how EH, EH Health Centers in Westford and Groton, Emerson Practice Associates, and any health care professional providing services in the Hospital’s clinically integrated care setting, may use and disclose my protected health information (PHI), and also describes my rights concerning my PHI. I understand that I have a right to receive a paper copy of the Notice of Privacy Practices or that I may review an electronic copy at EH’s website www.emersonhospital.org. I acknowledge that I have been offered a copy of EH’s Notice of Privacy Practices.

5. Episode of Care: I understand that my consent to treat, release of information and assignment of insurance benefits is not limited to this date of service and may include multiple dates of service related to my current condition.

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Signature of Patient and Date of Birth	**Signature of Legal Guardian/Personal Representative and Date**	**State Relationship/Authority**