THE HAND CENTER
OF WESTERN MASSACHUSETTS

Patient Consent Form

Patient Name: _____D.O.B.: _____

The United States Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI (personal health information) is protected for patient privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment*, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat* you should you refuse to disclose your PHI. If you choose to consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I hereby authorize medical/surgical treatment*, care and/or services by The Hand Center of Western Massachusetts (HCWM) to the above patient. HCWM is authorized to contact me via telephone, cell phone, email, voicemail and text.

I authorize the HCWM to preserve any tissue for scientific or teaching purposes; to take photographs or videotapes for educational or diagnostic purposes; or to dispose of any remaining tissue or matter.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all related PHI on the above patient's medical history to HCWM.

I hereby authorize HCWM to release information regarding my medical treatment* to me (or parent or guardian as indicated below), my requesting physician(s) _____, my health insurance carrier(s) _____, to Therapy (ATI, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Baystate Medical Center, Baystate Noble Hospital, Baystate Wing Memorial Hospital, Berkshire Hand Therapy, Cooley Dickinson Hospital, Johnson Memorial Medical Center, Mercy Medical Center, Select Therapy), for testing (Baystate Medical Center Pain Management Clinic, Baystate R&I, Baystate Reference Labs, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Baystate Medical Center, Baystate Noble Hospital, Baystate Wing Memorial Hospital, Cooley Dickinson Hospital, Johnson Memorial Medical Center, Mercy Medical Center, Springfield Neurology, Western Mass Neurology), for equipment (EBI) and for surgical procedures (Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Baystate Medical Center, Baystate Noble Hospital, Baystate Wing Memorial Hospital, Cooley Dickinson Hospital, Johnson Memorial Medical Center, Mercy Medical Center, Pioneer Valley Surgicenter, LLC., Shriner's Hospital). I agree to waive any privilege I might have with regard to the PHI produced therein. In addition, I authorize _____ _____ to receive PHI about me.

HCWM is authorized to release any information acquired in the course of examination or treatment* to my employer's workmen's compensation insurance company/utilization review and the Department of Industrial Accidents pursuant to M.G.L. Chapter 152, Section 30A, if applicable.

I, the undersigned, hereby authorize payment to HCWM of medical/surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy. This includes insurance plans secondary to Medicare, specifically _____.

*Treatment includes but is not limited to Consultation, Evaluation, Independent Medical Examination and Section 36.
Revised 10/31/17

Patient Consent Form Continued

I fully understand that I am primarily and financially responsible for fees incurred by the above patient. I further understand that payment is not contingent on any settlement; judgment or verdict by which the above patient may eventually recover said medical/surgical fees. It is your responsibility to provide the HCWM with the most accurate and current or updated insurance and contact information. It is also your responsibility to provide any personal contact or insurance information changes in a timely manner. Failure to do so may affect our ability to properly bill your insurance and ultimately would become your financial responsibility. Knowingly providing the HCWM with false information in any way will void any other financial arrangements and your account would become due immediately. At times your insurance carrier may communicate a request for further information from you. Your response is required and must be communicated within a timely manner. Failure to respond to the carrier or within the time frame they request may lead to immediate denial or retroactive denial or recoupment of services and would become your immediate responsibility voiding any other financial arrangement you previously made with HCWM.

In the event that my account with The Hand Center of Western Massachusetts is delinquent for any reason, I agree to pay all expenses and costs of collection, including reasonable attorney's fees. I also agree to pay a service fee for collection costs in the amount of 1.50% per month of the unpaid balance until paid in full, if the account is more than thirty (30) days past due from the date of the private pay invoicing. I further agree if I do not give a 24-hour notice prior to my appointment to cancel I will be charged a service fee. There will be a $25.00 fee for any returned checks from the bank. If I am unable to make my copayment at the time of service I will be charged a $15.00 administrative fee per incident.

This authorization will remain in effect until my treatment* has ended or until I have revoked my authorization. I hereby authorize photocopies of this form to be valid as the original.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organizations named in this form.

Print Name: _____ Relationship: _____

*If patient is a minor, a parent or guardian must sign.

Signature: _____ Date: _____

*Patient, parent or guardian

*Treatment includes but is not limited to Consultation, Evaluation, Independent Medical Examination and Section 36.

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