PHYSICIAN GROUP PRACTICES

Owned & Operated by Littleton Regional Hospital
580 St. Johnsbury Road
Littleton, New Hampshire 03561
603-444-9000

Patient Name _____

DOB _____

CONSENT FOR HEALTH CARE SERVICES

1. **Consent to Medical Services**. I consent to and authorize medical treatment by the Practice (a wholly owned subsidiary of Littleton Regional Hospital), Littleton Regional Hospital (LRH), their respective employees, students and other individuals involved in my care as may be advisable to evaluate or treat my medical condition. I understand that such treatment may include diagnostic procedures such as laboratory, x-ray, electrocardiogram monitoring, and other treatment(s) under the general or specific instruction of my physician. I acknowledge that I may be required to sign additional "informed" consent forms for certain specific medical treatments or procedures. I understand the practice of medicine is not an exact science and I acknowledge the Practice and LRH have made no guarantee or assurance to me as to the effect, result, or outcome of any examination or treatment I may receive.
2. **Release of Information.** I authorize the Practice and LRH to release medical or other information about me to: (1) physicians, other health care practitioners, and health care institutions (including pharmacies, pharmacy exchanges and/or pharmacy databases) that are involved in my continued care and treatment, including referrals; and (2) my insurance company, HMO, or other third-party payor(s) (including Medicare and Medicaid), as necessary for the Practice and/or LRH to bill and receive payment for my care. I recognize that the information released may include sensitive information such as alcohol/drug abuse treatment, mental health and HIV/AIDS information, and I authorize the release of all such information as necessary.
3. **To assist us in providing the best possible uninterrupted service to you, please answer the following questions:**

   May we contact you: At home? ☐ Yes ☐ No At work? ☐ Yes ☐ No

   What is the best way to contact you? ☐ phone: H_____ Cell_____ W _____

   ☐ mail:_____

   ☐ fax #: H_____ W _____

   May we leave a message if you are not home? (Information will be limited ONLY to date and time if call is for appointment reminders and the name of individual calling or the Practice name). ☐ Yes ☐ No

   May we discuss your health information and billing information with a family member, spouse, or other person involved in your care or payment for your treatment or services rendered? ☐ Yes ☐ No

   If Yes, Individual's Name(s): _____

   _____

   _____
4. **Notice of Privacy Practices.** I acknowledge receipt of the LRH Notice of Privacy Practices (NPP). This notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand I have the right to receive a paper copy of this Notice at any time, or that I may review an electronic copy at *www.littletonhospital.org.*
5. **Assignment of Benefits and Financial Responsibility.** I authorize payment directly to the Practice or LRH of any insurance or third party benefits (otherwise payable to me) to which I am entitled for my treatment at the Practice. I understand that I am responsible for providing LRH with information necessary to allow the Practice or LRH to bill my insurance. I understand that I am financially responsible for payment of any charges not paid by insurance or other third party, including if I have no insurance or if coverage is denied. If my account is referred to a collection agency or attorney, I agree to pay reasonable attorney's fees and collection expenses.
6. **Medicare/Medicaid Payment.** I certify that the information given by me in applying for, or assigning, payment under Medicare or Medicaid is correct. I request that payment of authorized benefits be made to the Practice and/or LRH on my behalf. I authorize the Practice and LRH to release any information about me that is necessary to act on this request for payment.

I have read the information on this form (or had it read to me). I have had an opportunity to ask questions and have had them answered to my satisfaction. I understand and agree to all of the terms above unless otherwise noted. I certify that I am the patient or the patient's legal representative with authority to sign this document on the patient's behalf.

_____ _____

Signature of Patient / Agent under Durable Power of Attorney for Health Care / Legal Guardian (Circle One) | Date and Time

Patient is unable to sign because: ☐ Minor ☐ Temporarily incapacitated ☐ Permanently incapacitated

ORIGINAL - Medical Record