

EMERSON HOSPITAL

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE
AND
CONSENT TO TREAT/ DISCLOSE HEALTH INFORMATION**

ACKNOWLEDGMENT OF RECEIPT OF EMERSON’S NOTICE OF PRIVACY PRACTICES:

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, Emerson Practice Associates, Concord Gastroenterology Associates, any health care professional providing services in the Hospital’s clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson")."

CONSENT FOR TREATMENT/TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultants as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson may treat me, seek payment from third parties for such treatment, and generally carry on Emerson’s health care operations (e.g., quality assurance). I also authorize Emerson to disclose my medical/insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY

In consideration of services rendered, I hereby irrevocably assign and transfer to Emerson Hospital, its physicians, assistants and consultants rights, title and interests in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to sue or make claim for benefits, individually, should coverage be denied by an insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital and its physicians, assistants, and consultants all benefits due under said policy(ies) by reason of services rendered therein. I will pay Emerson Hospital, its physicians, assistants, and consultants for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies) that my providers are permitted to collect. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Print Name

Date

Signature of Patient

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of
Personal Representative

Description of
Authority

Date