PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Lifespan Family Healthcare, LLC to use and disclose protected health information (PHI) about me to conduct treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by Lifespan Family Healthcare, LLC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifespan Family Healthcare, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Manager, 80 River Road, Newcastle, ME 04553.

I have the right to request that Lifespan Family Healthcare, LLC restrict how it uses or discloses my PHI to conduct TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

The practice utilizes automated calls and texts - with this consent, Lifespan Family Healthcare, LLC **may call my home or text my cell phone** about any items that assist the practice in carrying out TPO such as reminding me of appointments, announcements, billing, and health notifications. **Home phone ☐ yes ☐ no**
Cell Phone ☐ yes ☐ no

With this consent, Lifespan Family Healthcare, LLC **may e-mail** any items that assist the practice in carrying out TPO, such as reminding me of appointments, announcements, billing and health notifications. **☐ yes ☐ no**

With this consent, Lifespan Family Healthcare, LLC may share my records via Health Data Sharing. **☐ yes ☐ no**
Health Data Sharing allows MaineHealth to send us your medical records.

With this consent, Lifespan Family Healthcare, LLC may share my records via Healthinfonet. **☐ yes ☐ no**
HealthInfonet is a secure computer system that brings your health information from different healthcare locations into one statewide electronic health record. This helps providers in different locations make better decisions about your care, such as in the emergency room. (see more information and Opt-Out form on our website).

With this consent, Lifespan Family Healthcare, LLC may share my records with ImmPact. **☐ yes ☐ no**
ImmPact is the Maine state immunization program. This program strives to ensure full protection of all Maine children from vaccine-preventable disease. Sharing the records helps keep your immunization data updated.

The following person(s) may contact Lifespan Family Healthcare, LLC inquiring about my health information. You have my permission to release information to them.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone_____

_____ _____
Signature of Patient or Legal Guardian Print Name of Legal Guardian, if applicable

_____ Date_____
Print Patient's Name

RELEASE OF BILLING INFORMATION, ASSINGMENT OF BENEFITS AND FINANCIAL POLICY

RELEASE OF BILLING INFORMATION

I authorize the release to the Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of Lifespan Family Healthcare, any personal, medical or billing information needed for billing claims. I understand I will be responsible for deductibles, copays and coinsurance, and any non-covered services not paid by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits to Lifespan Family Healthcare, LLC.

MEDICARE/MEDICAID AUTHROIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare LLC for any services furnished to me by the Providers at Lifespan. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agent's information needed to determine benefits. If I have other insurance, my signature authorizes releases of information to that insurer or agency. In Medicare/Medicaid assigned cases, the physician agrees to accept the determination of the carrier as payment in full and the patient is responsible for deductibles, copays, coinsurance, and any non-covered services.

FINANCIAL POLICY

As a courtesy to our patients, we file most insurance. Please be aware that some or all the services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt. We cannot file your insurance unless you have your card with you. Your insurance must be current and verifiable at the time of treatment. Copays and payment for non-covered items are due at the time of treatment. Self pay services are due at the time of service. We charge $35 for "No Show" appointments, to be paid prior to or on your next appointment. We accept cash, checks and major credit cards. Should it be necessary to utilize outside collection means for past due account, you are responsible for all costs, including attorney, court, and collection fees. A minimum $35.00 fee will be assessed on all returned checks.

I have read and understand the Release of Billing Information, Assignment of Benefits and Financial Policies of Lifespan Family Healthcare, LLC and have completed this form to the best of my ability and will not hold Lifespan Family Healthcare, LLC responsible for my errors or omissions.

_____ _____

Signature of Patient or Legal Guardian Print Name of Legal Guardian, if applicable

_____Date _____

Print Patient's Name