UCONN HEALTH

(Patient Identification)

CONSENT FOR TREATMENT, USE AND DISCLOSURE OF PHI, ACKNOWLEDGMENTS AND FINANCIAL AGREEMENT FORM

CONSENT FOR TREATMENT: I voluntarily consent to care and treatment by UConn Health and its affiliates, including John Dempsey Hospital, UConn Medical Group, UConn School of Medicine, University Dentists, and UConn School of Dental Medicine (together "UConn Health"). Treatment includes but is not limited to physical and mental examination, diagnostic tests, medical procedures, medications, testing for HIV (the virus that causes AIDS) and use of audiovisual technology for medical purposes ("Treatments"), by the medical staff, employees, residents, other trainees and authorized agents of UConn Health as may be considered necessary or advisable in their professional judgment. I understand that I have the right to make informed decisions regarding my care and Treatments, and this right includes the right to refuse any Treatments that I do not want.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI"): I authorize UConn Health to use and disclose my PHI for treatment, payment and health care operations as permitted by law, including sensitive PHI such as drug, substance and/or alcohol abuse information, psychiatric information, and information related to HIV.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: To the extent required by law, I have been offered a copy of the UConn Health Notice of Privacy Practices and have received or declined the Notice of Privacy Practices.

FOR STAFF USE ONLY: If unable to obtain, indicate the reason:
☐ Emergency ☐ Patient refusal ☐ Other: _____

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY: I authorize and assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to UConn Health for services rendered. I agree to be responsible for all permissible billing charges that are not covered by either insurance or another source of payment. I understand that I may refuse to sign this form. If I refuse to sign this form, I understand that I will be responsible for all permissible payment obligations arising out of my treatment or care, which may include payment of deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier or UConn Health's self-pay policy.

_____ _____

Print Name **Date** **Time ☐ AM ☐ PM**

_____

Patient Signature or Authorized Representative*

* must provide proof of relationship (unless parent of a minor child)

Please check relationship to patient:
☐Self ☐Parent ☐ Legal Guardian ☐ Conservator ☐ Healthcare representative
☐ other authorized representative (specify): _____

HCH901