

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

GENERAL AGREEMENT

General Information:

I request care from one or more of the following organizations, for treatment of my medical and/or mental health condition, and/or for the routine or intensive care of my child:

- Beth Israel Deaconess Medical Center (BIDMC)
- Harvard Medical Faculty Physicians at BIDMC (HMFP)
- Beth Israel Deaconess Healthcare (BID-Healthcare)

This care may include medical tests, exams, or treatments that are needed for my (my child's) condition.

I agree to this treatment and care.

Use and Disclosure of Medical Information:

BIDMC, HMFP, and BID-Healthcare may disclose to others and request from others my medical information. My information may be shared for treatment, healthcare operations, and payment purposes. Information shared may include information about my mental health or substance abuse treatment, but only the information necessary to coordinate my care.

- I agree to the sharing of my medical and mental health information for treatment, healthcare operations and payment purposes.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my mental health or substance abuse treatment with other providers to coordinate my care.
- I have the right to request a restriction or limitation on how my medical or mental health information is used or shared. I understand that these organizations may not be able to act on all of my requests.
- I have the right to take back my consent, in writing, except when my consent has already been acted upon.

Insurance and Payment Information:

BIDMC, HMFP, and BID-Healthcare receive payment from insurance companies, Medicare, and/or other third party programs.

- I agree to let my doctor(s) and/or BIDMC submit claims and treatment information to my insurance program (private insurance, Medicare, etc.) for payment and to evaluate the quality of care I receive.
- I agree to have my insurance program make payments directly to BIDMC, HMFP, and BID-Healthcare.
- I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance program.
- I agree to let BIDMC, HMFP, and BID-Healthcare share information about my inpatient or outpatient mental health or substance abuse treatment with my insurance program for payment purposes.

Special Note about Mental Health Benefits:

I understand that if I am using my health insurance benefits to pay for mental health treatment, and/or substance abuse treatment, my insurance program may need some information from my clinician(s).

The information that insurance companies need for initial sessions of **outpatient** treatment is limited to diagnosis, and type of treatment. However, if my outpatient treatment is to go beyond those initial sessions, then my insurance company will need additional information. If I am going to receive mental healthcare as an outpatient, I understand that my insurance company may have limits on the number of visits that it will pay for. I need to stay informed of my plan's mental health benefits.

If I am going to receive mental health treatment as an **inpatient**, my insurer will request information from my clinicians about my hospitalization. This additional information allows my insurer to determine if the treatment is medically necessary and if payment for treatment will be authorized.

Please continue on the reverse side.



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 - continued -

Durable Medical Equipment: Durable Medical Equipment (DME) is medical equipment to be used outside the hospital and at home. Examples of DME include nebulizers, wheelchairs and blood pressure monitors. I understand that it is my responsibility to obtain any DME that my healthcare professional says that I need. I am responsible for any and all costs not covered by insurance.

Release of Liability for Retention of Valuables: I understand that it is not wise to keep personal valuables with me while I am in the Medical Center. I understand that the BIDMC staff is willing to keep my valuables safe by placing them in a secure location while I am in the Medical Center. I understand that if I keep my valuables with me, and they are either stolen or lost, BIDMC does not have any liability and they will not reimburse me for the item(s).

The Healthcare Team: Beth Israel Deaconess Medical Center is a teaching facility. I understand that treatment and care will be provided by a team of healthcare providers headed by a staff doctor. I understand that this healthcare team may include resident doctors, nurses, and clinical students / staff. These healthcare team members may also watch or take part in my treatment and care.

Instructions for Patients: Please sign sections A and B.

A. General Information: I have read this form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form.

X _____ OR
 Patient's Signature Print Name

X _____ and _____
 Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ___/___/___ Time: ___:___:___ a.m. p.m.

B. Privacy Notice: I have received copies of the BIDMC "Notice of Privacy Practices" and "Your Rights and Responsibilities as a Patient". BIDMC has the right to change privacy practices. Any changes will be effective for medical information BIDMC already has about me as well as information BIDMC receives in the future. I am aware that I may request an additional or revised copy of "Notice of Privacy Practices".

X _____ OR
 Patient's Signature Print Name

X _____ and _____
 Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ___/___/___ Time: ___:___:___ a.m. p.m.

INTERPRETER (if applicable) – Name or ID Number: _____

