Beth Israel Deaconess Medical Center
Boston, MA 02215

GENERAL AGREEMENT

MR0446

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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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.

Beth Israel Deaconess HealthCare®

Patient Financial Responsibility Guidelines

Beth Israel Deaconess HealthCare (BIDHC) is pleased you have chosen our practice for your medical care. Quality care is a first priority among our providers. To reduce confusion and keep costs of your care to a minimum, BIDHC requests that you please read the following guidelines to understand your financial responsibility and requirements.

Patients with Health Insurance

- Please bring your insurance card to each visit so that the office staff can verify your eligibility.
- Not all services may be covered by your insurance plan therefore the obligation to understand what services are covered remains with you. Please contact your insurance carrier regarding covered services.
- If your insurance requires a referral to see one of our MDs for specialty care, please contact your PCP's office. The referral will need to be in place prior to your visit.

Co-Payments

- Co-payments will be expected on each date of service when required by your insurance.
- Please understand co-payments may be required when problems are addressed during your annual physical visit.
- If you have questions regarding your co-pay amount, please call your health plan directly.

Worker's Compensation (WC) / Motor Vehicle Accident (MVA) Visits

- Please inform both the scheduling and check-in staff that your visit is due to either a work-related injury or a motor vehicle accident.
- WC and MVA insurance carriers require related forms to be filled out in order for reimbursement of your claims to occur. Please bring your employer, worker's compensation, auto insurance carrier and/or attorney information to your office visit.
- Patients will be billed directly if the above information requested is not provided to our offices.

Establish PCP with your Health Insurance

- If your health insurance requires the selection of a primary care physician (PCP), please make sure this is in place prior to your appointment.
- Patients may be responsible for the visit if the PCP has not been established with your health plan.

Self-Pay Patients

- A deposit for services provided in the physician office is expected at the time of your visit. Any remaining balance will be billed to you.

No Shows

- We require 24 hour cancellation notice if you are unable to keep your appointment.
- Please understand that you may be charged a no show fee for missed appointments.

Billing Questions

We realize that special circumstances may arise and will assist you in every way we can to resolve your outstanding balances. Financial hardship discounts are available. To apply please contact our Billing department.

Please understand we reserve the right to transfer delinquent accounts to a collection agency after all efforts have been exhausted to obtain payment from you.

Statements sent to you from BIDHC are for the physician's portion of the visit. Hospital, laboratory and radiology services may be billed to you separately from those facilities. Please call them directly when bill questions arise.

Please feel free to contact our Billing department with any questions at **(617) 754-0730** between the hours of **8:00am-4:00pm, Mon – Fri** or email askapg@bidmc.harvard.edu at your convenience.

X ***Patient Signature***_____***Date:*** _____

I acknowledge receipt of these patient financial responsibility guidelines.

Beth Israel Deaconess HealthCare®

Additional Registration Questions

For regulatory reasons, we ask that you provide us with the following information.
We understand that not all patients may be comfortable providing this information. If you choose to decline to provide this information, we will respect your wish.

What is your **Marital Status**?

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Partner
- ☐ Patient Declined

In what **Language** do you prefer to discuss your health related concerns?

- ☐ English
- ☐ Other: _____
- ☐ Patient Declined

What is your **Race**?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ White
- ☐ Other: _____
- ☐ Patient Declined

What is your **Ethnicity**?

- ☐ Hispanic or Latino/Spanish
  - ☐ Central American
  - ☐ Cuban
  - ☐ Dominican
  - ☐ Mexican
  - ☐ Puerto Rican
  - ☐ South American
  - ☐ Spaniard
  - ☐ Other: _____
- ☐ Not Hispanic or Latino
- ☐ Other: _____
- ☐ Patient Declined

Beth Israel Deaconess HealthCare®

Patient Representative Authorization Form

By filling out this form I am giving permission to Beth Israel Deaconess HealthCare (BIDHC) to talk to the person(s) listed as my patient representative about my past, present, and future health information. I understand my health information may include general health information such as appointment times and medications as well as sensitive information such as testing and/or treatment of communicable disease, HIV/AIDS, drug and alcohol abuse, and behavioral/mental health matters. I also understand that it is my responsibility to tell my representative(s) if I give them permission to share the information they receive with others. If they do share the information with others, those actions may not be protected under federal and/or state law.

I understand my permission given to BIDHC does not expire until I cancel or change it. Cancellation or changes to my permission may be made at any time and must be made in writing and sent to my Primary Care Physician's office. I understand that cancellation or changes will not apply to information already communicated to my representatives. I also understand that cancellation or changes will not begin until my written request is received by my Primary Care Physician's office. If I want to change my representative(s), I must complete a new form. I understand that when I fill out a new form, my previous form is no longer valid.

I voluntarily give my permission to BIDHC to talk to my representative(s). I do not need to sign this form to assure treatment. If I have questions about the disclosure of my health information, I understand that I can contact the BIDHC Compliance Office at (617) 754-0541.

My Information (Patient)

Name:_____ Date of Birth: _____

Street:_____

City: _____ State: _____ Zip: _____

Patient Representative(s): Please list individuals you want to be your representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure he/she has this information.

1. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____
2. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____
3. Representative's Name: _____

   Relationship to Patient:_____Telephone #: _____

I understand by signing below I give permission to BIDHC to talk to my representative(s) listed above about my health information without restrictions.

Patient Signature: _____ **Date:**___/___/_____ **Time:**_____ **o a.m.** **o p.m.**

Print Name: _____

If signed by legal representative, relationship to patient: _____