Lawrence Memorial Hospital

Authorizations/Agreements/Insurance Assignments

1. **Communication about Your Care:** Concerned family members or friends often ask questions about your care or your children's care. To protect your confidentiality, the physicians, nurses, and other LMH staff will not discuss your care with anyone besides you, unless we have your permission to do so. I give the LMH staff permission to discuss my protected health information with the below individuals. I understand I can make changes to this list at any time by notifying a staff member in writing:

   ______________________________ ______________________ __________________
   Name Relationship Phone Number

   ______________________________ ______________________ __________________
   Name Relationship Phone Number

   ______________________________ ______________________ __________________
   Name Relationship Phone Number

2. **Leaving Messages:** I authorize the LMH to leave a message on my:
   ___ Primary Phone (Number_____________________________)
   ___ Secondary Phone (Number_____________________________)
   ___ Other Phone (Number_____________________________)

3. **LAB/RADIOLOGY TESTS:** When lab/radiology tests are ordered in the clinic, your results will be communicated by phone to you. During that phone call you may request a copy of your lab results to be mailed to you. Please indicate below if you authorize the mailing of your test results upon verbal request.

   ___YES I authorize my test results to be mailed upon my verbal requests ___ **NO** I will fill out a release EACH time to get my results.

4. **HIPAA Privacy Policy:** You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. My signature below acknowledges that I have been offered a notice of the privacy practices of Lawrence Memorial Hospital.

5. **Insurance Companies:** We will provide medical information and any other billing information to your insurance companies as necessary to bill for and substantiate the service you received in order to obtain payment for services provided.

6. **Assignment of Benefits:** I hereby assign to LMH any medical benefits arising out of any policy of insurance insuring the patient to be applied to the charges for services rendered. I understand I am financially responsible to Lawrence Memorial Hospital for charges not covered by this agreement. I agree not to revoke this assignment without written notice to LMH and any such revocation attempted will not be effective without notice from the insurance company to LMH. A copy of this assignment shall be as valid as the original.

7. **Financial Agreement:** I authorize Lawrence Memorial Hospital to bill and collect for their professional services. I understand and agree that LMH is not responsible for collecting insurance or for resolving any disputed insurance or other third party payer claim and to pay LMH all costs and charges incurred in connection with the services provided. It is agreed that if full payment is not made by insurance or other third party payer, the patient/guardian assumes responsibility for all remaining charges. I understand that a $30.00 returned check fee will be assessed for checks returned for any reason. I understand that a $50.00 fee may be assessed for failure to notify the clinic one business day in advance that I will not be able to keep my appointment and for cancellations the same day of the appointment.

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ THE FOREGOING AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR IS DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT.

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__________________________________ ___________________ ___________________
Print Patient Name Date of Birth Date

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Patient Signature, Guardian, Agent or Representative Relationship to patient

Revised 12/27/12, 06/11/2014