GREENWICH BAY MEDICINE &
BLACKSTONE VALLEY MEDICINE
DIVISIONS OF MDRI

GENERAL CONSENT FOR TREATMENT/RELEASE OF INFORMATION/PRIVACY POLICY

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to the rendering of medical care, treatment and diagnosis, therapeutic or medical procedures to be performed by my healthcare provider, his/her designee or assistants as is necessary in his/her judgment.

USE AND RELEASE OF INFORMATION:

I understand that MDRI/Blackstone Valley Medicine/Greenwich Bay Medicine will keep records that pertain to my medical, personal and other information related to my diagnosis, care and treatment in electronic, paper, and other forms. I understand that MDRI/ Blackstone Valley Medicine/Greenwich Bay Medicine may release any information about me, my health the health services provided to me that maybe necessary: (1) for my treatment to other health care providers or facilities that need the information for my continued care; (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process insurance claims), for utilization and review or for billing and collection purposes or (3) for health care operations of MDRI or another health care provider that has a relationship with me.

TELEMEDICINE:

I understand that MDRI may use telemedicine during my care and treatment. Telemedicine can use audio and video equipment to permit a two-way, real-time, interactive communication between a patient and a healthcare provider. The information gathered during a telemedicine visit will be maintained in my medical record, and privacy, and confidentiality of my medical information will be maintained at all times. I understand that I have the right to withdraw my consent for telemedicine at any time without affecting my right to future care or treatment.

ASSIGNMENT OF BENEFITS:

I hereby assign to MDRI the right to all my health insurance benefits otherwise payable to me, and I authorize Medicare and/or my medical insurance benefits to be paid directly to MDRI/BVM/GBM. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

FINANCIAL RESPONSIBILITY:

I understand that my insurance may not pay the full amount of all my charges, and I acknowledge that I am financially responsible for non-covered services, as well as deductibles and coinsurances or any amounts in excess of my insurance benefits. If I am uninsured, I assume responsibility for payment of my charges. I understand and agree that I will be charged a fee of fifty dollars for cancelation of appointments with less then twenty-four hours' notice and two or more no showed appointments.

CONSENT TO USE OF TEXT MESSAGES:

I consent to the receipt of text messages from MDRI/BVM/GBM and or its agents for the phone number that I provide. If I do not wish to continue to receive text messages, I can discontinue this service at any time.

NOTICE OF PRIVACY RIGHTS & PRACTICES-ACKNOWLEDGEMENT STATEMENT:

I acknowledge that I have received a copy/or have had the opportunity to review the MDRI Notice of Privacy Practices. I understand that this notice describes the ways in which BVM/GBM may use and disclose my healthcare information for treatment, payment and healthcare operations. I understand that I may contact the privacy officer if I have questions or a complaint.

Patient's Signature: _____ Date: ____/___/_____

(or signature of parent/representative or guardian if applicable)