CONNECTICUT COLON AND RECTAL SURGERY, LLC
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Social Security Number: _____ **Primary Physician:** _____

E-mail address: _____

We will not share your e-mail address or use it to transmit medical or clinical information.

Mailing Address: _____

1) I have been offered or received a copy of Connecticut Colon and Rectal Surgery, LLC "Notice of Privacy Practices."

2) I give my permission for Connecticut Colon and Rectal Surgery, LLC to contact me at the following numbers and to leave a message on my answering machine or voicemail(if none, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone (___) _____
Home / Mobile / Work (circle)

MESSAGES CONCERNING MEDICAL INFO Phone (___) _____
(For example, lab or test results) Home / Mobile / Work (circle)

3) Do you want appointment reminders via ☐ **TEXT MESSAGE or** ☐ **PHONE CALL**?

4) I give my permission for Connecticut Colon and Rectal Surgery, LLC. to communicate with the following persons regarding my health care:

Name: _____ **Phone #:**_____ **Relationship:** _____

Name: _____ **Phone #:**_____ **Relationship:** _____

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the office of Connecticut Colon and Rectal Surgery, LLC.

5) This is to certify that I consent to the administration of treatment by Connecticut Colon and Rectal Surgery, LLC. I consent to any examination or procedure or any other service rendered to me under the general or specific orders of Connecticut Colon and Rectal Surgery, LLC. I understand that, except in an emergency, all special procedures will be discussed with me by my physician and that an additional specific consent may be required. Unless revoked in writing, this permission will be valid for as long as I remain in the care of Connecticut Colon and Rectal Surgery, LLC.

6) I hereby authorize payment directly to Connecticut Colon and Rectal Surgery, LLC, for medical benefits otherwise payable to me. I understand that I am financially liable for charges not covered by this authorization. **I understand that all balances not paid within 30 days will be subject to additional finance charges at a rate of 18% APR. I also understand that if this account is not paid within 90 days, this bill will be sent on for further collection action and I will be responsible for the additional 15% fee associated with this action.** I hereby authorize Connecticut Colon and Rectal Surgery, LLC to release information required to support my claim. I also authorize any holder of medical information about me to release the information needed to determine benefits or benefits payable for related services, including requests for the purpose of FMLA or Disability.

7) I further understand that Connecticut Colon and Rectal Surgery, LLC charges a **$50 fee for missed appointments** and a **$500 fee for missed procedures** if I do not call to **reschedule at least 48 business hours prior to the appointment time**. **Business hours are considered Monday through Friday and exclude weekends and federal holidays**. This fee is not covered by insurance and will be my responsibility.

8) To better provide for your care and enhance your patient experience, we seek to coordinate and integrate our care delivery through our electronic medical record (EMR) which is paperless. We share access to the EMR across Hartford HealthCare (HHC), and some other HHC affiliated practices (accessed only as described in the Notice of Privacy Practices). Our current EMR does not functionally allow us to limit access to your record by blocking it from HHC or affiliated staff.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, all authorized health care providers and professionals at HHC and affiliates. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when Connecticut Colon and Rectal Surgery, LLC EMR no longer exists.

Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

☐ I choose to opt out and by doing so understand I decline to receive care at Connecticut Colon and Rectal Surgery, LLC.

_____ _____

Patient Signature **Date**

_____

Patient Printed Name

_____ _____

Parent or Guardian Signature **Date**

If the patient is a minor (under the age of 18) or has a guardian/conservator, this must be signed by the parent or legal guardian.