Mountain Community Health

61 Pine Street
Bristol, VT
Phone (802) 453-3911 Primary Care Fax (802) 453-6105 Dental Care Fax (802)453-3983

Patient Registration Consent Form

1. CONSENT TO TREAT

I (or my legal guardian or parents) authorize Mountain Community Health (MCH), the providers and healthcare team members to perform therapeutic medical or dental care reasonable by today's standards. I understand that I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

2. AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

I, the patient (or the policyholder if the patient is not the policyholder), authorizes and directs that all medical or dental benefits payable to or for the benefit of the Patient under the terms of any applicable insurance policy, be paid directly to the providers affiliated with MCH. Patients agree to sign any additional assignment of benefits form requested by MCH or any insurance company from time to time. Patients understand that they are liable to providers at MCH for all related charges, whether or not covered by insurance.

3. ASSIGNMENT OF MEDICARE BENEFITS

I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

4. AGREEMENT TO PAY CHARGES

I, the patient/guarantor (where applicable), agree to pay my share of costs for the services to be rendered by or through MCH providers in accordance with regular rates and terms. In the event of non-payment, patient, and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney fees. I understand that I may get bills from other outside third parties such as Quest Diagnostic, UVMHN, Dominion, Indivior etc. for services provided on my behalf like lab specimens, diagnostics, or medications.

5. CONSENT TO RETRIEVE EXTERNAL PRESCRIPTION HISTORY

I authorize MCH to obtain and use my external prescription history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

6. RELEASE OF INFORMATION

I acknowledge and understand that MCH may share my health information and records with other providers that are treating me for medical or dental services provided by MCH providers to any of the following: (a) my insurance company or any other third party insurance payer (b) my continuing care facility, (c) any organization involved in planning my discharge from MCH, (d) any organization performing utilization review pursuant to state or federal law, and (e) any health care agency authorized by law. I, the patient, acknowledges that the medical or dental records covered above may include information concerning conditions of mental illness, substance or alcohol abuse and worker's compensation.

The confidentiality of substance-use disorder records received by MCH from certain Substance Use Disorder Treatment Programs are protected under federal regulations (42 CFR Part 2) which prohibit any person or entity, including MCH, from making further disclosure of this information unless such disclosure is expressly permitted by my separate written consent or as otherwise permitted by 42 CFR Part 2.

7. CONSENT TO WIRELESS CALLS, TEXTS, AND E-MAILS

I consent to receive calls, texts, and emails from MCH, its agents or its representatives at the numbers and email addresses I provided during registration for the following purposes: appointment reminders, general health reminders, billing, and patient experience surveys. Messages may be generated and sent using an automated notification. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message data rates may apply depending on my contract with my carrier. I understand that I have the right to revoke this consent orally or in writing.

_____ _____

Signature of Patient (if older than 12 years old) **Date**

_____ _____

Signature of Parent or Authorized Representative **Date**

Relationship to Patient: _____