Student Name__________________
Date of Birth __________________

Maranacook Student Health Center
MaineGeneral Health Associates

Patient Registration Form for
Consent to Treatment, Assignment of Benefits,
and Release of Information

I. Consent to Treatment

I authorize MaineGeneral Health and its subsidiaries (**Maranacook Student Health Center** as listed above), physicians, staff, contracted agents, and other individuals involved in my care to examine me and perform any tests and/or treatments that may be helpful to care for my injuries or illness.

I understand that the healthcare provider responsible for this care will explain the reasons for any tests and treatment, as well as the benefits, the most common risks and alternative courses of treatment. I also understand that I have the right to refuse any suggested examinations, tests or treatment.

I understand that I may complete an Advance Directive, which allows me to direct the type of care that I will receive if I become unable to decide for myself. It also allows me to choose a surrogate decision-maker.

I understand that MaineGeneral and its contracted agents are dedicated to teaching, that authorized trainees may observe and assist in diagnosis and treatment, and that video recordings and/or photographs may be utilized for the purpose of diagnosis, teaching and documentation. I reserve the right to give specific permission for publication of any picture that personally identifies me.

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Patient or Legally Authorized Representative (state relationship to patient) Date

II. Payment and/or Assignment of Benefits

I understand that I am financially responsible for paying all costs associated with my evaluation, treatment and care. If I have health insurance, I understand that I may be financially responsible, consistent with my insurance coverage and state law. I am also responsible for those charges not covered by my health insurance such as deductibles, co-pays, and evaluations, treatments and care that are not included as an insurance benefit. I authorize my health insurance carrier(s) or other third party payers, including Medicare and CHAMPUS/ TRICARE that are responsible for paying for my health care to pay the costs associated with my evaluation and care, directly to MaineGeneral Health, its subsidiaries (**Maranacook Student Health Center)**, physicians, staff and contracted agents.

III. Notice of Privacy Practices

MaineGeneral's Notice of Privacy Practices provides information about how MaineGeneral may use and disclose my protected health information. I understand I have the right to review the notice before signing this consent. The notice is available at check-in locations and outpatient areas throughout MaineGeneral, and online at www.mainegeneral.org. If changes are made to this notice, a revised copy will be made available. I have the right to request that MaineGeneral restrict how my protected health information is used or disclosed for treatment, payment or healthcare operations. I understand that MaineGeneral is not required to agree to this restriction, but if it does, MaineGeneral will be bound by our agreement.

I have the right to revoke this consent, in writing, except where MaineGeneral has already made disclosures in reliance on my prior consent.

My signature under Section IV indicates that I have been offered or provided a copy of MaineGeneral Health's Notice of Privacy Practices.

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IV. Release of Health Care Information

I understand that information concerning my evaluation, treatment and care is available to those involved in my care for treatment, payment or healthcare operations, or as required by law. I authorize MaineGeneral, its subsidiaries (**Maranacook Student Health Center** as listed above), physicians, staff and contracted agents to share my health information with other health care providers as necessary to develop my plan of care, to continue my care and treatment and to provide for my follow-up care.

I also authorize MaineGeneral, its subsidiaries (**Maranacook Student Health Center** as listed above), physicians, staff and contracted agents to release my health care information to the extent necessary to my insurance carrier(s), their reviewers or others paying for this care. This authorization is effective until final payment is received, unless rescinded.

Under Maine law, providers may disclose some health information to certain people. These disclosures are limited to the amount of information reasonably required for the purpose of the disclosure. I understand that MaineGeneral will release information to the specific recipients below unless I have crossed them out.

General Applicability:

Family or Household Members

Inpatient and Emergency Department Admissions Only:

Facility Directory (name, room number and health status)
Clergy (name, room number, place of residence, religious affiliation)
Media, if requested (name, general health status)

Specific authorization is required to disclose mental health and substance abuse treatment information and HIV testing and treatment information, unless authorized by law.

Patient or Legally Authorized Representative (state relationship to patient) Date

V. Specialized Release

Federal laws require my specific consent for providers to exchange information pertaining to drug, alcohol or other substance abuse treatment information.

State laws require my specific consent for providers to exchange information pertaining to mental health treatment and HIV testing or treatment.

I understand that I may request to review any such information in my medical record, and may refuse to disclose some or all of my medical records. However, such refusal may result in improper diagnosis, treatment, denial of insurance benefits or other adverse effects.

My authorization to exchange this information for payment purposes will expire when my bill is paid.

My authorization to exchange this information for communication among my caregivers will not exceed one year from the date of my signature.

I specifically authorize the exchange of this information to:

- ❑ My Personal Physician(s) as identified in my medical record
- ❑ HealthReach Network's Division of Community Support & Counseling
- ❑ My insurance company as identified in my medical record

If my record contains information pertaining to HIV testing or treatment, mental health or substance abuse treatment, I agree to the exchange of this information for billing, payment, discharge planning, and continuity of care by checking my agreement with the release of the specific information, and by signing below:

- ❑ HIV testing or treatment information
- ❑ Mental health treatment information
- ❑ Substance abuse treatment information

Patient or Legally Authorized Representative (state relationship to patient) Date

Please return this completed form to the high school health center or the middle school wellness center by September 7, 2007. Thanks!