

# Westbrook Medical Center

## “Consent for Purposes of Treatment, Payment & Healthcare Operations”

(In this document, “I” and “my” refer to the patient, and “facility” refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Print Name of Patient or Representative

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Representative’s Authority

### CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient’s blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B, Hepatitis C, or HIV.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

I decline to authorize the above testing:

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date