Vasectomy Center of Connecticut

Permission/Release/Notice/Financial

CONSENT TO TREATMENT AND DIAGNOSTIC PROCEDURES: "This is to certify that I, the undersigned, consent to the administration of treatment at the Vasectomy Center of Connecticut (VCC) by its physicians and ancillary providers. I consent to any x-ray, laboratory, medical procedures of examination and other services rendered to me under the general and specific instruction of Dr. Matson. I understand that, except in emergency, all special procedures including vasectomy will be discussed with me and that an additional specific consent form will be required. Unless revoked in writing this permission will be in effect while I am under the care of the Vasectomy Center of Connecticut."

AUTHORIZATIONS TO RELEASE MEDICAL INFORMATION: "I consent to allow the VCC, as defined above, to disclose my protected health information within VCC, to carry out my treatment, to obtain payment, and to carry out health care operations. My protected health information may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My protected health information may be disclosed to outside heath agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency purposes. My physician may also share information with referring physicians for continuing care as deemed appropriate by me. My protected health information may include medical information or any pertaining to the examination, treatment, history, which may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information, and charges to my health plan and/or their acting intermediaries and/or agents. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to Dr. Matson."

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES: "I understand that specific information regarding the uses and disclosures of my medical information can be found in the PWH Notice of Privacy Practices which has been provided to me and which I have a right to review before I sign this. I further understand that the VMIC has a right to change its Notice of Privacy Practices and that I may obtain a revised copy at the practice web site www.VasectomyCT.com. I understand that I have the right to request in writing that VCC restrict how my protected health information is used and disclosed for treatment, payment and health care operations. I further understand that VCC is not required to agree to my requested restrictions. However, if VCC agrees to a requested restriction, it is bound by it."

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY: "I understand that I am responsible for payment for all services provided at VCC. VCC will provide documentation of services provided, including applicable CPT codes and charges, for submission to insurance carriers for consideration of insurance re-imbursement. Decisions about re-imbursement are not made by VCC, but will be made by my insurance carrier based on my specific insurance plan. Deposits for future services are non-refundable should I cancel or not show for planned appointments."

_____ _____

Signature of Patient Date

Patient has: ___ refused to sign; ___ been unable to sign though good faith efforts have been made.
Explanation: