EMERSON PRIMARY CARE
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO TREAT/DISCLOSE HEALTH INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF EMERSON'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, the Emerson Hospital Health Centers in Westford and Groton, Emerson Hospital Radiology at Concord Hillside, Emerson Practice Associates, Emerson Primary Care or any health care professional providing services in the Hospital's clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson").

CONSENT FOR TREATMENT/TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultants as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson's health care operations (e.g., quality assurance). I also authorize Emerson to disclose my medical/insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY:
In consideration of services, rendered, I hereby irrevocably assign and transfer to Emerson Hospital, its physicians, assistants and consultants rights, title and interests in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to sue or make claim for benefits, individually, should coverage be denied by an insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital and its physicians, assistants, and consultants all benefits due under said policy(ies) by reason of services rendered therein. I will pay Emerson Hospital, its physicians, assistants, and consultants for all charges incurred or alternatively, for all charges in excel of the sums actually paid pursuant to said policy(ies) that may providers are permitted to collect. A photostatic copy of this authorization shall be considered as effective and valid as the original

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Signature of Patient Date

If patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

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Signature of Personal Representative Description of Authority Date