ANCHOR HEALTH

Anchor Health - Hamden
2200 Whitney Ave, Suite 290
Hamden, CT 06518

Anchor Health - Stamford
30 Myano Lane, Suite 16
Stamford, CT 06902

PATIENT CONSENT FORM

For you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. Please read and initial below each item prior to your first appointment.

By signing, you are indicating your agreement.

1. Consent for Treatment

I am voluntarily seeking medical care and treatment from Anchor Health Initiative Corp. *("Anchor Health")* and give permission to the medical staff of Anchor Health to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

Initial for Consent for Treatment:

2. Payment Responsibility

I agree to pay Anchor Health for all services. If I do not have medical insurance or Anchor Health does not participate with my insurance, I understand that I am responsible for all charges incurred and I will pay for all services in full at the time of service. If I am insured:

- *I have given Anchor Health the information necessary to determine my eligibility for such insurance coverage.*
- *I authorize Anchor Health to bill my insurer directly. I assign to Anchor Health all insurance reimbursements otherwise payable to me for services and direct my insurer to pay all reimbursements directly to Anchor Health. I will promptly endorse any insurance reimbursement I receive over to Anchor Health.*
- *I assign to Anchor Health any legal or administrative claim, appeal, or other cause of action I may have under my health plan in connection with Anchor Health's services.*
- *I authorize Anchor Health to release my health care information to my insurer for payment purposes.*
- *I am advised that any tests (including blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.*
- *I understand that my insurance may not cover all charges deemed medically necessary by Anchor Health. I understand that I am responsible for paying for all charges that are not covered by my insurance.*
- *I will pay any copayments, coinsurance, and/or deductibles required by my insurer.*
- *I will pay any amount not billed at the time of service within 30 days of Anchor Health's bill.*

Initial for Acceptance of Responsibility:

3. Consent for Certain Disclosures and Uses of Medical Information

I specifically consent to the following uses and disclosures:

- *My medical information may be used and disclosed for treatment, payment, and health care operations (TPO) without my consent, unless I have requested that Anchor Health restrict how it uses or discloses my medical information to carry out TPO and Anchor Health did not refuse my request.*
- *Anchor Health may access and use prescription history data made available to Anchor Health, including prescriptions written by other health care providers, solely for TPO.*
- *If I have not indicated otherwise in writing, Anchor Health may contact me by any means at any address, phone number, or email address I have provided to Anchor Health.*

Initial for Consent for Disclosures and Uses:

4. Patient Rights and Responsibilities

I have received and reviewed a copy of Anchor Health's Patient Rights and Responsibilities and agree to abide by such document.

Initial for Agreement to Rights and Responsibilities:

(Continued on the next page)

I have read all items in this Consent or had them explained to me and I understand and agree to its contents.

Name of Patient: *(PRINTED)*	**Date:**
Signature:	
Name of Person Signing: *(PRINTED)*	

If not signed by patient, please check off the basis for your authority to sign this Consent:

☐ Parent of minor ☐ Guardianship order ☐ Power of attorney ☐ Conservator of person ☐ Other: _____