10197 (01/27/2022)

CARE NEW ENGLAND

☐ Butler Hospital ☐ CNE Medical Group
☐ Kent Hospital ☐ The Providence Center
☐ VNA of CNE ☐ Women & Infants Hospital

**FOR INPATIENTS:** AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

**FOR OUTPATIENTS:** WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ____________________________

DOB OR MR #: ______________________________

# PATIENT FINANCIAL AGREEMENT AND GENERAL CONSENT

This is a Care New England Standard Patient Financial Agreement and General Consent used when registering patients at any Care New England affiliated hospital which includes Butler, Kent, or Women & Infants, and each of their outpatient clinic locations, The Providence Center, the VNA of Care New England, and any Care New England Medical Group or WIH Faculty Physicians practice site (each individually, a "CNE Site").

**CONSENT TO TREATMENT:**
**I understand** that my care will be provided according to my attending provider's orders. I understand that when I request care for my medical condition I am generally consenting to other medical treatments such as x-ray examinations, laboratory tests and minor procedures that my provider may order. I further understand that photographs, videotapes, audiotapes, digital or other recordings may be taken for identification purposes or to document my medical condition or care and for internal educational purposes. For major procedures, such as a surgery, my provider will explain them to me and I will be asked to sign a separate consent form.

**HEALTH CARE EDUCATION:**
**I understand that CNE Site** is a teaching facility where individuals in training, residents, fellows, medical students, nursing students and other health care students may be observers or participants in my care under the direct or indirect supervision of licensed practitioner(s).

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**
I understand that CNE Site can release all necessary health information for purposes of treatment, payment and healthcare operations as permitted by applicable law. This includes disclosures and/or requests by telephone, fax, photo copy or electronic means which may include HIV/AIDS related information, substance use disorder treatment information and information about diagnosis or treatment of mental illness, as permitted by law. I understand that this information may be shared with other treating providers, third party payers and any designated Caregiver, including, but not limited to, insurance companies (and their review organizations), managed care organizations, Medicare, Medicaid or other governmental payers that may provide coverage and reimbursement for services rendered to me by the Hospital, or other third parties, including information pertaining to my identity, prognosis, diagnosis, treatment or any other information necessary to establish my eligibility for insurance benefits. I understand that the CNE Site will share my health information for treatment purposes through a Health Information Exchange (HIE), as permitted by law. I further understand that I can opt out of the CNE Site sharing with a HIE by making an Opt Out request in writing.

I further release the CNE Site and its employees from any liability arising from the release of this information to such persons/agencies, provided that the release of information is done substantially in accordance with applicable law.
I further understand and agree that if, in connection with my care and treatment by a CNE Provider, (1) I receive inpatient care at Butler Hospital; OR (2) receive mental health or substance use disorder related treatment (drug or alcohol) at The Providence Center; OR (3) I receive substance use disorder-related treatment (drug or alcohol) at one of the following programs: [Women and Infants Mom's Matter Clinic, one of Butler Hospital Outpatient Substance Use Program: Ambulatory Detox, Adult Psychiatry, Research, Partial Hospital, Adult Intensive Outpatient, Kent Hospital: Kent Psychiatric Unit at Butler Hospital], I am also being asked to extend my consent to the following statements:

**CONSENT TO BUTLER HOSPITAL AND CNE'S 42 CFR PART 2 PROGRAMS TO DISCLOSE MY INPATIENT PSYCHIATRIC AND DRUG/ALCOHOL TREATMENT INFORMATION** - I hereby grant my consent to disclose (share) my inpatient psychiatric care and substance use disorder-related medical record information, including but not limited to my history, diagnosis, medication, treatment and other such identifying information, to other treating providers and professionals that have been identified as being involved in my treatment and care, whether or not they practice at a CNE affiliate. I understand that I may revoke this consent in writing with notice to Butler Hospital or the CNE 42 CFR Part 2 Program(s) where I have obtained inpatient psychiatric or drug or alcohol treatment at any time; provided, however, that I cannot withdraw my consent for disclosures that have already been made in reliance on my original consent. I understand that I have the right to request a list of entities to which my drug or alcohol treatment information has been released by a CNE 42 CFR Part 2 Program pursuant to this consent in the two years prior to my request.

I acknowledge that I understand this consent form and that it means certain treatment information that is protected under the Rhode Island mental health law and federal confidentiality regulations at 42 CFR Part 2 can be released to my CNE patient portal(s) and my treating providers and professionals.

**WORKER'S COMPENSATION:**
**If** my care is related to an accident at work, I understand that my employer's Workers' Compensation carrier will also have access to all information contained in my medical record.

**ASSIGNMENT OF INSURANCE BENEFITS:**
**To the extent permitted by law, I irrevocably assign to CNE Site and** other providers furnishing services to the patient any and all benefits of any type arising out of any claim or policy of insurance insuring the patient or any willing party liable to the patient. I authorize and request that payment of insurance benefits be made on my behalf for any services furnished to me by or in the CNE Site, including provider services.

**FEDERAL MEDICARE BENEFITS:**
**I certify that the information given by me** in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or their intermediaries or other agents any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider or organizations furnishing the services or authorize such provider or organization to submit claims to Medicare for payment to me. I acknowledge and agree that, to the extent permitted by law, I am responsible for payment for any services provided not covered by Medicare.

**FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT:**
**I** acknowledge that I am legally responsible for all charges incurred in connection with medical care and treatment provided by CNE Site and providers providing professional services to me through the CNE Site (hereinafter "Providers"). I agree and consent to medical care that has been or will be provided to the patient whose name appears above. For services rendered by the CNE Site and Providers, I guarantee payment of the account and agree to pay such account at the time services are rendered if payment for such services are not covered by my insurance carrier or other third-party payer ("Payer"). I understand that Payer may require authorization prior to my receiving treatment and that it is my responsibility to obtain that prior authorization and know the coverage of my plan. I understand that receiving prior authorization does not guarantee that my Payer will pay because the benefits permitted depend upon my individual healthcare plan. I understand that Providers may not balance bill me for non-emergency services provided to me at a CNE Site if Providers are out-of-network with my Payer, unless I receive prior notice by and provide consent to CNE Site or Providers. I acknowledge that if my child/dependent is cared for by CNE Site or Providers I will be responsible for payment for services provided under these same terms and conditions.

**COMMUNICATIONS:** By signing this consent, I understand and agree that CNE Site can use my telephone number, cell phone number, mailing address or email address I have provided in order to send messages. Messages may include, but not limited to, appointment reminders, patient portal message notification, surveys, questionnaires or billing/payment issues. By agreeing to these electronic transmissions, I acknowledge that the privacy and security of electronic communications cannot be guaranteed and that parties with whom I have chosen to share electronic addresses or phone numbers may be aware of such transmissions and may have the means to access my personal health information using information from these transmissions.

**PERSONAL BELONGINGS:** I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the CNE Site. I hereby release the CNE Site from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

**SIGNATURE:** I have read the information above or have had it read to me. I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have voluntarily consented to the above.

_________________________________ _______________
Signature of Patient (Date/Time)

_________________________________ _______________
Signature of Authorized Representative (Date/Time)

_________________________________________________
Relationship to Patient

_________________________________ _______________
Signature of Witness (Date/Time)