JONATHAN A. BENJAMIN, M.D.,
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As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Privacy Rule sets Standards of Privacy to protect individual's personal health information and gives patients increased access to their medical records. We are required to comply with the Privacy Rule as of April 14, 2003, and to provide you with an explanation of our Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the doctors, physicians assistants, nurses, administration staff, and other providers of health care who work with this practice are called "providers". I understand that if I want to receive treatment, or I want my child to receive treatment, from one or more of these providers, I need to give permission for them to share information about my health or my child's health among themselves and with other individuals for treatment and billing purposes and other health care operations.

I also understand that all reasonable efforts will be made to protect the privacy of this health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by e-mail or facsimile mail.

By signing below, I agree that any of the providers associated with the Practice may:

1. Use this health information, on a need to know basis, to provide treatment.
2. Share my health information with others who are involved with my care/my child's care, either in or outside of this Practice.
3. Use this health information for billing reasons.
4. Share this health information with health insurance companies, government agencies, or other payors that request information related to benefits determination, claims filed for my visits and other billing matters.
5. Use this health information within the Practice and share it outside the Practice for health care operations (including *for example*, teaching, monitoring the quality of care and making improvements where needed, making sure providers are qualified (licensing, certification and credentialing), and carrying out other business and administrative activites).

I understand that the Practice has a Notice of Privacy Practices (the Notice) that describes in more detail how this health care information is used and shared with others. The Notice explains:

(1) when I need to give further approval for the providers to use this health information or share it outside the Practice and,
(2) when my permission is <u>not</u> needed for the providers to use this health information or share it outside the Practice (for example, if required by law, or as allowed for law enforcement purposes and legal proceedings, public health and health oversight activities, organ and tissue donation purposes, and certain approved research activities).

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this consent.

I understand that Jonathan A. Benjamin, M.D. and Roger W. Spingarn, M.D., L.L.C. has reserved the right to change the Notice at any time and I may obtain a current copy of the Notice by contacting the office at 617-244-9929.

I understand that I have the right to request that the providers restrict how my health information/my child's information is used or shared to carry out treatment, payment and other health care operations as described in the Notice. The providers are not required to agree to my restrictions, but if they do, the restriction is binding.

I understand that I may revoke this consent, in writing, except to the extent that the providers have already acted on it. I also understand that if I revoke this consent, my providers have the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my/my child's health information as described above.

Parent Signature:____________________________ Date:_______________

Print Name:____

OR

Patient Signature (if ≥18 years):____________________________________

Date of Birth:______________________________ Date:_______________

PATIENT REGISTRATION FORM

Patient's Name:_______________________________________ **Date of Birth:**____/____/______ **Gender:**_______________
Sibling 1 Name:_______________________________________ Date of Birth:____/____/______Gender:_______________
Sibling 2 Name:_______________________________________ Date of Birth:____/____/______Gender:_______________
Sibling 3 Name:_______________________________________ Date of Birth:____/____/______Gender:_______________
Sibling 4 Name:_______________________________________ Date of Birth:____/____/______Gender:_______________
Street Address:____
City/Town: ____State:__________Zip:_________________
Home phone:___________________________________Patient's Physician:____________________________________
Race: ☐ White ☐ Asian ☐ Hispanic ☐ Black or African American ☐ American Indian
☐ Native Hawaiian or other Pacific Islander ☐ Other Race ☐ Unreported/Declined
Ethnicity: ☐ Hispanic or Latin American ☐ Non Hispanic or Latin American ☐ Unreported/Declined
Primary Language: ___________________________ Translator Required?: ☐ Yes ☐ No

Parent:_________________________________
☐ Mother ☐ Father
Home Phone:____________________________________
Cell Phone: ____________________________________
Email: ____
Date of Birth: __________________________________
Address: (☐ same as above)_______________________
City: ____
State:_______________Zip: _______________________
Occupation:_____________________________________
Business phone:__________________________________

Parent:_________________________________
☐ Mother ☐ Father
Home Phone:____________________________________
Cell Phone: ____________________________________
Email: ____
Date of Birth: __________________________________
Address: (☐ same as above)_______________________
City: ____
State:__________________Zip: ____________________
Occupation:_____________________________________
Business phone:__________________________________

Who is the Guarantor (**financially responsible person**) for this patient's account (**if different from above**):
Name:____Relationship:_______________________________
Date of Birth:____Phone:_____________________________________
Street Address: ____
City/Town ____State___________Zip ________________

INSURANCE INFORMATION (Please fill out information completely)
Insurance Co. and Plan Type:____
Address:____Phone:___________________________
Subscriber Name:______________________________________Relation to patient:__________________________
DOB:__________________________________Social Security #:_______________________________________
ID Number:_________________________Suffix:_____________________Group:____________________________
Group Number:______________________ Co-pay for Well Visit________ Co-pay for Sick Visit:_______
☐ THE PATIENT'S INSURANCE CARD has been provided TO PHOTOCOPY

PREFERRED PHARMACY (Name, Street, Town):____
HOW DID YOU HEAR ABOUT OUR OFFICE?:____
☐ I authorize the release of any medical information to process claims. I authorize payment of medical benefits to the provider that rendered services.
☐ Insurance co-payments are due at the time of service. I understand that an administrative fee will be added to each co-payment not paid at the time of service.
☐ I understand that I am financially responsible for medical services *not* covered by my insurance company. I will notify the office of any changes in my child's health insurance information.
☐ I have read and signed the *Consent for Use and Disclosure of Protected Health Information* (over).

Patient or parent/legal guardian signature:_______________________________________Date:________________
Print patient or parent/legal guardian name:____