BROWN MEDICINE
BROWN PHYSICIANS, INC.

Consent to Treat and Patient Registration

I consent to be treated by Brown Medicine providers and to participate actively with them in the management of my health care needs. This consent includes authorization to review any prescription history.

Patient (or Legal Guardian) Signature: _____ Date: _____

Please Print

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address _____ Patient Portal Option ☐ Yes ☐ No

Date of Birth _____ Social Security # _____ Gender _____

Marital Status ☐ S ☐ M ☐ D ☐ W Other: _____ Race _____ Ethnicity _____ Language _____

Referring Provider _____ Primary Care Provider _____

Responsible Party: Last Name _____ First Name _____ Initial _____

Emergency Contact _____ Relationship _____ Cell Phone _____

Preferred Pharmacy _____ Address _____

Insurance Information

Primary Insurance _____ Policy Effective Dates: From _____ To: _____

Policy Holder name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Patient Relation to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance _____ Policy Effective Dates: From _____ To: _____

Policy Holder name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Patient Relation to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other _____

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, the patient is responsible for the bill, interest, and collection and attorney fees. I authorize payment directly to the undersigned Provider for my charges and authorize the undersigned Provider to release any information regarding my examination or treatment to my insurance company in writing or by fax.

Patient (or Legal Guardian) Signature: _____ Date: _____

File: Patient Admin Docs with naming convention: YYYYMMDD Consent to Treat

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AUTHORIZATION TO DISCUSS PERSONAL PROTECTED HEALTH INFORMATION

This authorization permits **Brown Medicine** staff and physicians to discuss and/or disclose protected health information to the Designated Party(ies) named below. This authorization allows the designated Party(ies) to make or confirm appointments, have access to test results and financial health information, be involved in communications concerning diagnosis, prognosis and treatment plans.

I hereby authorize **Brown Medicine** to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that once this information is released to the Designated Party(ies), the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Designated Party: _____ Relationship to Patient: _____
Address: _____ Phone: _____

Designated Party: _____ Relationship to Patient: _____
Address: _____ Phone: _____

Designated Party: _____ Relationship to Patient: _____
Address: _____ Phone: _____

☐ No one at this time.

Please read the three statements below carefully before signing this document.

1. I understand that I may revoke this Authorization at any time by notifying **Brown Medicine.** However, if I do revoke the Authorization, it will not have any influence on any actions taken in reliance upon this Authorization by **Brown Medicine** prior to the receipt of the revocation.
2. I understand that my treatment will not be affected if I do not sign this Authorization.
3. I understand that this Authorization is effective for the lifetime of the patient unless revoked.

Signature of Patient (or Legal Guardian) _____ Date: _____
Printed name of Patient (or Legal Guardian) _____

Please read the statement below carefully before signing below this section.

I understand that sensitive information such as that regarding substance abuse, HIV, sexually transmitted disease, or mental health issues require additional authorization. I hereby authorize **Brown Medicine** to disclose this additional information as indicated below.

☐ **Same as above.**
☐ No one at this time.

Designated Party: _____ Relationship to Patient: _____
Address: _____ Phone: _____

Signature of Patient (or Legal Guardian) _____ Date: _____
Printed name of Patient (or Legal Guardian) _____

File: Patient Admin Docs with naming convention: YYYYMMDD HIPPA

BROWN MEDICINE
BROWN PHYSICIANS, INC.

BROWN MEDICINE / BROWN MEDICINE ENDOSCOPY CENTER

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

We are legally required to give you this Notice and to obtain your signature noting that you have received it. The Brown Medicine Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes rights you have about your health information kept by us.

I, _____, acknowledge that I have received the Brown Medicine Notice of Privacy Practices.

I understand that Brown Medicine employs my physician along with other Brown Medicine practitioners and staff at Brown Medicine offices. I also understand that Brown Medicine owns and maintains my medical records and, as stated in the **Notice of Privacy Practices** has assured me that Brown Medicine keeps information about me confidential as required by state and federal laws. I know that if I want to have access to my medical records or copies of any information contained in the record, I should ask anyone at Brown Medicine for assistance.

I also understand that any questions or concerns about this notice or the confidential management of my medical record may be directed to the office of the Brown Medicine Chief Compliance Officer at (401) 443-4999.

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

Print Name: _____

FOR OFFICE USE

A good faith attempt was made to obtain the patient's signature; however, we were unable to do so due to:

☐ Patient Refusal to Sign ☐ Other/Comments: _____

Staff Signature: _____ Date: _____

Print Name: _____

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CONSENT TO TREATMENT

I consent to treatment by the practice for a wellness visit, evaluation and/or treatment of an injury or illness or to address another medical concern.

I authorize the practice, its health care practitioners and personnel, including members of its medical staff, and others involved in my care, to examine me and to perform any tests, procedures and treatments that in their judgment may be helpful to care for me or to treat my injury or illness or facilitate my preventive care.

I understand that this consent includes authorization to review any prescription history.

I understand that the health care professionals responsible for this care will explain any proposed procedures or treatments, including their usual and most frequent risks and hazards. I also understand that I have the right to refuse any proposed procedure or treatment.

I understand that during my care, I may be examined and treated by physicians and other personnel as part of their supervised training. I understand that I may opt-out of their participation in certain instances at the time of my visit.

I understand that information concerning my diagnosis and treatment will be available to other health care professionals and facilities involved in my ongoing care or treatment including through electronic health information exchange networks. I understand that if I wish to opt-out of Health Information Exchange (HIE) I must notify my health care Provider.

I understand that I may complete an Advance Directive. An Advance Directive allows me to direct the type of care that I will receive if I become unable to decide for myself. It also allows me to choose someone to make those decisions for me.

I understand that photographs, videos, and audio or digital recordings may be made for identification purposes, or to document my medical condition or care. I further understand the use of personal electronic devices by patients and/or visitors for the purpose of taking and transmitting photographs, video or audio recordings, of patients, medical staff members, or employees is prohibited. I understand that security cameras are in place in certain public areas of Brown Medicine facilities.

I understand that this authorization will remain valid until revoked to the extent possible by me or my legal representative verbally or in writing to Brown Medicine. Revocation of authorization cannot be applied retroactively.

Print Patient Name	Date of Birth
Patient Signature	Date Signed
Print Name of Personal Representative	Print Name of Interpreter