Patient Information and Consent Form

Patient Name _____ Date of Birth _____

Address _____

I. General Consent

I hereby consent to allow Benjamin G. Newman, M.D., d/b/a The Village Doctor (the "Practice"), to conduct any assessment or evaluation that he determines may be helpful to my diagnosis and treatment. I understand that these services may include physical examinations, review of my medical records, consultation with other health care professionals, scoring and interpreting test results, and other activities used to collect information for my assessment and treatment. I understand that any specific diagnosis or treatment will be explained to me, along with their usual and common risks and hazards. I also understand that I have the right to refuse any proposed test or treatment.

Patient's or Authorized Representative's Signature _____ Date _____

II. Use of Health Care Information

I understand that the Practice will make use of my health care information for purposes of treatment and other lawful functions of the Practice, including securing payment and other usual health care operations. I understand that this information may be available to persons working on the Practice's behalf, who will be subject to the same duty of confidentiality as the Practice with respect to my information.

I understand that if the Practice holds certain sensitive information related to my health care, such as: (i) records covered by federal rules governing confidentiality of alcohol or drug abuse treatment programs; or (ii) records concerning my diagnosis or treatment for HIV infection, then my specific authorization will be required to disclose such information outside the Practice. However, I consent to the use of such information by the Practice for purposes of my diagnosis and treatment, and I understand that such information may be made available to persons working on the Practice's behalf, who will be subject to the same duty of confidentiality as the Practice with respect to such information. I understand that I may refuse to allow the sharing of some or all such information within the Practice, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

Patient or Authorized Representative _____ Date _____

III. Disclosures of Health Information and Notice of Privacy Practices

I acknowledge that I have received a copy of the Practice's "Notice of Privacy Practices," which describes in more detail how my health information may be used or disclosed and how I can get access to this information.

I understand that it is the Practice's policy to treat all health care information and records as confidential, and not to disclose them unless authorized to do so. I understand that I have the right to control the disclosure of my health care information, subject to certain disclosures that are permitted or required by law, and that my health care information will not be disclosed unless: (i) I have specifically authorized the disclosure; or (ii) the disclosure is permitted or required by law.

I understand that it is the Practice's policy not to share any of my health care information with my family or household members, except as specifically directed by me. The family or household members, if any, with whom I direct the Practice to share my health care information are the following:

_____

The information that the Practice may share with those persons consists of:

_____

_____ _____

Patient or Authorized Representative Date

IV. Payment and/or Assignment of Benefits

This office runs on a fee-for-service basis. However, if the Practice has agreed to bill a third party on my behalf, such as my insurance carrier, I understand that I am financially responsible in the event that all or some payment is denied by my health insurance carrier or other third party responsible for making payment on my behalf. I am also responsible for those charges not covered by my insurance, such as deductibles, co-pays, or full payment for any evaluations or treatments that are not covered by insurance benefits.

If the Practice has agreed to bill a third party on my behalf, I authorize my health insurance carrier(s) or other third parties responsible for making payment on my behalf to pay the costs associated with my evaluation and care directly to the Practice. I understand that the Practice will disclose my health care information, to the extent necessary, to my health insurance carrier(s) or other third parties responsible for making payment on my behalf, or to their authorized agents (such as reviewers).

_____ _____

Patient or Authorized Representative Date