Harmony Healthcare LI, Inc. Consent Form

Consent to Treatment: I authorize Harmony Healthcare LI, Inc. (HHLI) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of HHLI's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by HHLI personnel. HIV testing is now a part of routine care and written consent is no longer required. I do have a right to decline HIV testing at any time. The HHLI offers family planning services. I understand that my acceptance of family planning services is not a prerequisite to eligibility for, or receipt of, any other services that is offered by the HHLI.

Release of Information: I authorize HHLI to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable HHLI to obtain payment for the services it provides to me; and (3) to permit HHLI to carry out ordinary health care and business operations such as quality assurance, service planning and general administration. I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic disease

I am aware that Harmony Healthcare LI, Inc. may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits: I assign to HHLI all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by HHLI

Financial Obligations: I agree, that, except as may be limited by law or HHLI's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at HHLI facilities in accordance with the rates and terms of HHLI in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

No- Show Policy – Important Notice:
Please remember to be courteous to us and other patients by calling **at least 4 hours prior** to your appointment time to cancel if you cannot make it. This will allow us to serve our patients better. Patients arriving **more than 15 minutes late** for their appointment will be counted as a no show and they will need to reschedule their appointment.

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Signature of Patient or Representative: _____ Date:_____

Nature of Relationship to Patient (if patient not signing): _____

Reports to NYS Immunization Information System: I hereby authorize HHLI to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

Signature of Patient or Representative: _____Date:_____

516-296-3742
www.harmonyhealthcareli.org