Patient Name: _____ **Date of Birth:** _____

Consent Form for LRH Clinics, Urgent Care and Ancillary Departments

I give providers of Littleton Regional Healthcare (LRH) permission to treat my medical condition and order or perform testing, including but not limited to labs and x-rays. I understand that I have the right to stop treatment and testing. I am aware that the practice of medicine is not an exact science and no guarantee can be made about the result of any exam or treatment I may receive.

Assignment of Benefits

I give my health insurance company or other payment sources permission to pay LRH directly for any services provided to me, and give LRH permission to bill my health insurance company or other payment sources directly.

My Financial Responsibility

I understand that payment for health care services is always my responsibility, and that I must pay for any charges not covered or partially covered by my health insurance or other payment sources for any reason, including, but not limited to, deductibles, co-insurance, and co-payments. I understand that if I am not insured, I must pay for my care out-of-pocket or make other payment arrangements. I understand that I am responsible for providing LRH with information necessary to allow LRH to bill for the services provided to me. I understand that if my account is sent to a collection agency or attorney, I will be responsible for paying LRH's reasonable attorney's fees and collection costs.

Release of Information

I give LRH permission to release information to my insurance or other payment sources for payment and benefits determination. I give LRH permission to share information with other providers involved in my care. I understand that this may include such sensitive information as mental health, psychotherapy, HIV testing, drug and alcohol treatment or other such records.

Notice of Privacy Practices

LRH offered me a copy of the Notice of Privacy Practices. This notice describes how medical information about me is used and how I can get access to this information.

Patient Satisfaction Surveys

I understand that LRH uses a separate agency to mail out surveys and that I am not required to take part.
This consent will expire one year from the date below.

SIGNED: _____ DATE: _____
(Circle One) Signature of Patient/Agent under Durable Power of Attorney for Health Care/Legal Guardian/Surrogate)

Littleton Regional Healthcare
600 St. Johnsbury Rd
Littleton, NH 03561