Sean P. Heffernan, M.D., LLC
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Email: sph@drseanheffernan.com

INFORMATION AND CONSENT FORM

Name: _____
Please sign initials on line to indicate consent/acknowledgement.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT

_____ I give consent to Sean P. Heffernan, M.D., LLC to release health information by mail, phone, or fax to staff at my pharmacy for purposes of prescribing medication or clarifying medication issues. If my health plan requires pharmacy benefit management (PBM), I give consent to Sean P. Heffernan, M.D., LLC to release information to the PBM for the purpose of prescribing medication or clarifying medication issues.

_____ I give consent to Sean P. Heffernan, M.D., LLC to release health information by mail, phone, or fax to staff at laboratories (Quest, LabCorp, hospital labs, etc.) for the purpose of providing laboratory services.

_____ I give consent to Sean P. Heffernan, M.D., LLC to release health information by mail, phone, or fax to my health care providers as described in the *Notice or Privacy Practices*, although specific authorization with verbal and written permission is preferred.

CONSENT FOR RELEASE OF INFORMATION FOR HEALTHCARE OPERATIONS

_____ I give consent to Sean P. Heffernan, M.D., LLC to share necessary health information with staff it may hire to assist with billing, scheduling, or other office operations.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, OR HEALTH-RELATED PRODUCTS OR SERVICES

_____ I give consent to Sean P. Heffernan, M.D., LLC to contact me by phone or email if he offers appointment reminders, treatment alternatives, or health-related products or services.

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN & ASSIGNMENT OF BENEFITS

_____ I give consent to Sean P. Heffernan, M.D., LLC to release medical information to my insurance company. I certify that the information I have reported with regard to my insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e. treatment plans) or verbally (i.e. requesting

benefit/authorization information by phone). I permit a copy of this consent to be used in place of the original. I may revoke this consent at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. If my insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services, including late cancellations/missed appointments, telephone appointments, services provided after benefit exhaustion, and services determined not to be necessary by my insurance carrier.

_____ I do not give consent to Sean P. Heffernan, M.D., LLC to apply for benefits or to release medical information to my insurance company. I accept responsibility for payment of all medical service provided. I agree to pay for all out-of-network or non-covered services including later cancellations, missed appointments, telephone appointments, services provided after benefit exhaustion, and services determined not to be necessary by my insurance carrier. I understand that my benefits may be reduced or absent because no information will be released to my insurance carrier.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

_____ I understand that Sean P. Heffernan, M.D., LLC may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in situations detailed in the *Notice or Privacy Practices*.

POLICY REGARDING LATE CANCELLATIONS/MISSED APPOINTMENTS

_____ I understand and accept that if I miss a scheduled appointment or if I cancel an appointment with less than 48 hours notice, I am responsible for the full fee for that appointment. I understand that insurance companies do not pay fees for missed appointments or late cancellations. I understand that this policy applies to illness, injuries, work problems, childcare problems, and other last minute obligations. The only exception is a regional weather emergency.

EMERGENCY CONTACT POLICY

_____ I understand that if I have a psychiatric emergency, I should contact Dr. Heffernan. If I am unable to reach him, I will call 911 or go to the nearest emergency room.

NOTICE OF PRIVACY PRACTICES

_____ I have received a copy of Dr. Heffernan's *Notice of Privacy Practices.*

Signature: _____ Date: _____