New England Reproductive Medicine and Surgery LLC

Authorization to Treat

I voluntarily give my permission to the healthcare providers of ***New England Reproductive Medicine and Surgery, LLC*** and such assistants and other healthcare providers as they may deem necessary to provide medical services to me. I understand by signing this form I am authorizing them to treat me for as long as I seek care from ***New England Reproductive Medicine and Surgery, LLC*** providers or until I withdraw my authorization in writing.

HIPAA Privacy Policy

I acknowledge that I have read and understand the 'Notice of Privacy Practices' and that ***New England Reproductive Medicine and Surgery, LLC*** has offered access, via their website at www.nermas.com , to a copy of their 'Notice of Privacy Practices' in compliance with current HIPAA regulations.

Release of Information and Assignment of Benefits

I hereby authorize ***New England Reproductive Medicine and Surgery, LLC*** to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim. Additionally, I hereby authorize payment directly to ***New England Reproductive Medicine and Surgery, LLC*** of the medical and/or surgical benefits, if any, otherwise payable to me for the services as described.

Authorization for Disclosure of Information

Our providers and/or staff may need, from time to time, to contact you. We would likely be contacting you about appointments as well as communicating information with you concerning your healthcare and financial responsibilities. Please provide us with the following information so that we can best interact with you and get our message to you:

Method of contact (check all that you approve) _____cell _____home

Preferred Phone Number: _____

If there is someone other than yourself that you would like us to be able to share your healthcare information with, please provide us with their information:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

If there are healthcare providers that you would like us to be able to share your healthcare information with, please provide us with the following information. (Check all that you approve. If another provider, please provide their name):

____ **Referring** Provider on file ____ **Primary Care** Provider on file ____**Other** Provider:_____

Authorization of Secure Telemedicine Communication

We are delivering telemedicine services for certain appointments through **doxy.me™** to continue our dedication to providing exemplary care for our patients. This platform meets the HIPAA requirement of a HIPAA-secured platform and will require that you have access to both email and the internet.
By providing your preferred email address, you are accepting and authorizing this platform as a means of communication and access to **New England Reproductive Medicine and Surgery, LLC services**.

Preferred email address: _____

By signing below, I understand, agree with, and authorize the above five statements.

_____ _____
Printed Name of Patient Signer's Relationship to Patient, if other than Self

_____ _____
Signature of Patient / Guardian Date