Welcome to Wickford Family Medicine!

Name: _____Date of Birth_____
Month Day Year

Communication:

Email: Wickford Family Medicine (WFM) may email medical information and test results.
If I email **WFM** and do not get a reply quickly, I will email again or leave a phone message.

Phone: WFM may leave medical information by voice or text on my phone.

Notice of Privacy Practices and Patient Access to Medical Information:

WFM may use and disclose my medical information to:
1) Provide, coordinate and manage medical treatment with health care providers
2) Confirm coverage, bill for services and assess appropriateness of services
3) Conduct quality assessment, audit, cost analysis and evaluation of customer service

WFM may contact me regarding appointment reminders and treatment alternatives.

I place no restrictions on the medical information **WFM** may share with other health care professionals. I understand it will only be shared for the benefit of my medical treatment.

WFM may communicate with the following person(s):_____

I choose to not share this information: (Please mark circle to restrict or indicate no restrictions)
○ Psychiatirc ○ Substance Abuse ○ Sexually Transmitted Diseases ○ **No Restrictions**

I have the right to inspect and obtain a copy of my medical record.

If I feel my privacy rights have been violated, I have the right to file a complaint with **WFM**, the Department of Health and Human Services and the Office of Civil Rights.
WFM will not retaliate against me for filing a complaint.

Assignment of Insurance Benefits:

I have insurance coverage with _____
Name of Insurance Company
and assign directly to **WFM** all medical benefits otherwise payable to me for services rendered. I authorize **WFM** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Additional Comments:_____

By signing below I agree to terms related to communication, privacy, access to medical information and assignment of insurance benefits. I may alter my preferences at any time by written request.

_____
Patient or Patient Guardian Signature Date