MASSACHUSETTS EYE AND EAR INFIRMARY

DISCLOSURES TO OTHER HEALTH CARE PROVIDERS FOR COORDINATION OF CARE

Your Mass. Eye and Ear physician will coordinate your care with your other health care providers when he or she feels this would be helpful. He or she will use his or her judgment to determine whether and to which health care providers it is appropriate to provide information about your care.

To make sure that your Mass. Eye and Ear physician has contact information for your other health care providers, please indicate below the names of health care providers, such as your primary care physician or another specialist, to whom you would like your Mass. Eye and Ear physician to provide information about your treatments when he or she thinks this is appropriate.

Mass. Eye and Ear uses an electronic health record called LMR that allows certain other health care providers outside of Mass. Eye and Ear who provide you treatment, and who also use LMR, to "look up" information about your treatment at Mass. Eye and Ear without any action on the part of your Mass. Eye and Ear physician or you.

When your Mass. Eye and Ear physician determines it is appropriate, he or she may send a secure, electronic message through LMR to your health care providers who use LMR. Alternatively, he or she may also provide information to your health care providers who don't use LMR by mail, fax, telephone or secure e-mail.

1. ______________________________
(Name of Physician)

____
(Street Address)

____
City, State Zip code

______________ / ______________
Phone # Fax#

2. ______________________________
(Name of Physician)

____
(Street Address)

____
City, State Zip code

______________ / ______________
Phone # Fax#

3. ______________________________
(Name of Physician)

____
(Street Address)

____
City, State Zip code

______________ / ______________
Phone # Fax#

4. ______________________________
(Name of Physician)

____
(Street Address)

____
City, State Zip code

______________ / ______________
Phone # Fax#

Patient's Information:

(Place IDX Label Here.)

Patient's Signature: ______________________________

Form Issued 09/24/10

A Teaching Hospital of Harvard Medical School

Patient Sticker

Assignment of Insurance Benefits

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Mass Eye and Ear Associates and Mass Eye and Ear Infirmary for services furnished me by Mass Eye and Ear Associates and Mass Eye and Ear Infirmary. I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that if a MediGap policy or other health insurance is indicated on the claim form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mass Eye and Ear Associates and Mass Eye and Ear Infirmary.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

X

Patient Signature	

Acknowledgment of Notice of Privacy Practices

I acknowledge that I received the Massachusetts Eye and Ear Infirmary, and Massachusetts Eye and Ear Associates, Inc. Notice of Privacy Practices.

X

Patient Signature	

For Internal Use Only:
The patient above received the Notice of Privacy Practices and declined to sign this Acknowledgement.

Staff Member Name	
Staff Member Signature	

If patient is a minor or is otherwise unable to sign these Acknowledgments, the signature of a parent, guardian, or other legal representative is required:

☐ Assignment of Insurance Benefits ☐ Acknowledgment of Notice of Privacy Practices

Personal Representative Name	
Personal Representative Signature	
Relationship to Patient	

Massachusetts Eye and Ear

Human Studies Committee
Tel: 617-573-3732
Email: HSC@meei.harvard.edu

Mass. Eye and Ear Sinus Center Research Information Sheet

At the Mass. Eye and Ear Sinus Center, our goal is to not only provide world-class care for our patients but to also make the discoveries that continually improve health care. In order to do so, we would like to collect the information that you provide during your routine clinical evaluation, for example your clinic intake forms, in a data repository for conducting future research. It is through the generous participation of patients that we continue to improve the care that patients here, and around the world, receive.

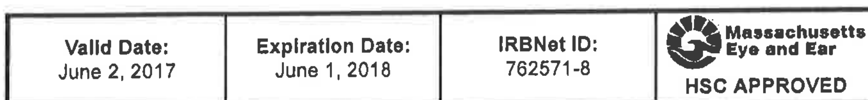
This will require no additional time or effort on your part and this will not at all impact the care you receive. Your participation is voluntary and your decision will have no impact on your relationship with your sinus surgeon or with Mass Eye and Ear.

When you are filling out your routine clinic paperwork, you are free to skip any question for any reason. There is a minimal risk in participating; there is always the risk for breach of confidentiality but this is always the case for your medical records whether you participate in this study or not. The information we will record simply includes the answers to the questions in your clinic intake forms, which consist of questions about your health problems, symptoms and medication usage. We will protect the confidentiality of your research information by storing it in a highly secure and encrypted database with access only to the sinus surgeons at MEEI who are conducting this study. You may not directly benefit from this study, but the information gathered from future studies may help in improving the care of individuals with your symptoms or condition.

By continuing, you are consenting to participate, with the understanding that you are free to withdraw at any time. If you do not wish to participate now, or if at any time in the future you wish to discontinue your participation, you may simply inform your sinus surgeon and it will not result in any penalty or loss of benefits to which you are otherwise entitled.

If you have any questions about this study, or have a complication or injury that you believe may be related to this data repository, please contact Dr. Ahmad R. Sedaghat, MD, PhD at 617-573-3209.

If you would like to discuss your rights as a research participant, or wish to speak with someone not directly involved in this study, please contact Mass Eye and Ear HRPP office at (617) 573-3732.



Valid Date: June 2, 2017	Expiration Date: June 1, 2018	IRBNet ID: 762571-8	Massachusetts Eye and Ear HSC APPROVED

HIPAA Authorization

WHAT IS THE PURPOSE OF COLLECTING, USING, AND SHARING OF YOUR PROTECTED HEALTH INFORMATION?

We are asking you to take part in the research study described in this research consent form. In order for you to participate we need to be able to collect, use and share your protected health information.

If you decide to be in this study, the researcher will get information that identifies you and your personal health information. This may include information that might directly identify you, such as your name and medical record number.

WE MAY COLLECT HEALTH INFORMATION ABOUT YOU FROM:

- Past, present, and future medical records

We are committed to protecting the privacy of your information. Any identifiable information that is obtained in connection with this study will remain confidential and will be disclosed only with your permission or as permitted by U.S. or State law. We will only collect, use, and share information that is needed for the research.

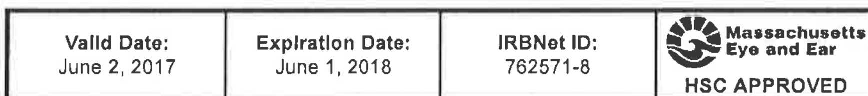
WHO MAY SEE, USE, AND SHARE YOUR IDENTIFIABLE HEALTH INFORMATION AND WHY THEY MAY NEED TO DO SO

MEEI research staff involved in this study:

- Other researchers, health care providers and medical centers in connection with this study and their ethics boards
- A group that oversees the data (study information) and safety of this research
- Non-research staff within MEEI who need this information to do their jobs (such as for treatment, payment (billing), or health care operations)
- Federal and state agencies (such as the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, and other U.S. or foreign government bodies that oversee or review research)
- Public health and safety authorities (For example, if we learn information that could mean harm to you or others, we may need to report this, as required by law)
- The study sponsor or drug regulatory agencies in other countries
- Governmental agencies to whom certain diseases (reportable diseases) must be reported
- Others as noted here:

All health care providers subject to the Health Insurance Portability and Accountability Act (HIPAA) are required to protect the privacy of your information. The research staff at the MEEI is required to comply with HIPAA and to ensure the confidentiality of your information.

We share your health information only when we must, and we ask anyone who receives



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it from us to protect your privacy. However, once your information is shared outside of MEEI, we cannot promise that it will remain private.

Some of the individuals or agencies listed above may not have to follow the same privacy and security rules that we follow and therefore may not be required to provide the same type of confidentiality protection.

The results of this research study may be published in a medical book or journal or used to teach others. However, your name and other identifying information will not be used for these purposes without your specific authorization.

FOR HOW LONG WILL PROTECTED HEALTH INFORMATION ABOUT YOU BE COLLECTED, USED, OR SHARED WITH OTHERS?

We will collect, use, and share your health information until the end of this research study, which may be after your direct participation in the research project ends.

Because research is an ongoing process, we cannot give you an exact date when we will either destroy or stop using your health information.

YOUR PRIVACY RIGHTS:

You may withdraw or take away your permission to use and disclose your health information at any time. However, if you withdraw your permission, you will not be able to stay in this study.

To withdraw, send written notice to the principal investigator listed in this consent form.

When you withdraw your permission, no new health information identifying you will be gathered after that date. Information that has already been gathered may still be used and given to others until the end of the research study, as necessary to insure the integrity of the study and/or study oversight.

____
Adult providing consent

______________________________ ______________________
Signature of adult providing consent **Date/Time**

____
Name of Legally Authorized Representative

______________________________ ______________________
Signature of Legally Authorized Representative **Date/Time**

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Sinus Center Medical Information Form

Date: ______/______/____________ Name: ______________________________

DOB: ______/______/____________ Age: ________

Address: ______________________________ City/State/Zip: ________________________

Home Phone: (______) ______-__________ Work Phone: (______) ______-__________

Email address: ____

Employment: ____

Were you referred? YES/NO Referring Physician's Phone Number: (_____) _____-_______

Name of Referring Physician: ____

Referring Physician's Address: ____

Emergency Contact

Name & Relationship: ____

Phone Number: (______) ______-__________

What are your current medications?

Do you have any allergies (Medications, Latex, etc..)?_____________________________

Please answer the following questions to the best of your ability in order to help us understand your health problems.