Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Health Operations

I, ____, understand that as part of my health care, **WEST ORANGE ORTHOPAEDICS**
(Print Patient Name)
originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnoses and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

****I fully understand WEST ORANGE ORTHOPAEDICS ONLY ACCEPTS CASH, "CASHIER'S CHECK'S" AND/OR MONEY ORDERS FOR THE FOLLOWING SERVICES:**

I understand **WEST ORANGE ORTHOPAEDICS <u>**uses a copy service**</u> and in the event of a records requests, an original written request along with photo ID must be provided to initiate the copying procedure. I am aware that I will be invoiced for requested copies and upon receipt of payment, my records will be provided. I understand **WEST ORANGE ORTHOPAEDICS** does not fax medical records on demand and I must request them with plenty of notice to have records mailed. Records request received via <u>**fax will not be accepted**</u>.

I understand **WEST ORANGE ORTHOPAEDICS does <u>**NOT**</u> release <u>original</u> x-ray films. And, **pre-payment for copies must be made in advance,** along with an original request and with photo ID. West Orange Orthopaedics <u>does not accept requests via fax</u>.

I understand **WEST ORANGE ORTHOPAEDICS charges for the completions of disability forms and family leave act forms. I understand that I must <u>allow 7-10 days</u> for completion of these forms. **I understand that these forms are to be given to the front office staff upon arrival to ensure proper form completion.** I understand that these will not be faxed but may be mailed or picked up by an authorized person upon completion. We do not provide phone updates for disability insurance companies. Each disability or FLAct form is considered a <u>one-time authorization</u> to provide information to these companies.

****I understand Coinsurance and Deductibles (down payments) for surgeries must be paid no later than one business day before procedure.**

I understand **WEST ORANGE ORTHOPAEDICS** uses scheduling services for outside referrals and it is my responsibility to verify with my insurance company(s) that an authorization/referral has been obtained as well as the facility or physician is contracted with my insurance company.

I understand **WEST ORANGE ORTHOPAEDICS** does <u>**not**</u> **phone in prescriptions** in the evenings or on the weekends. I am aware that I must give West Orange Orthopaedics <u>**72 hours**</u> **notice to refill my prescriptions**.

I understand **WEST ORANGE ORTHOPAEDICS** shares orthopaedic call with Sports Medicine Institute and if I phone in on the weekends and/or holidays, my return call may be from David Lucas, M.D. and/or Kevin Nowicki, M.D.

I understand **WEST ORANGE ORTHOPAEDICS** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand **WEST ORANGE ORTHOPAEDICS** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **WEST ORANGE ORTHOPAEDICS** change their notice, they will send a copy of the revised notice to the address I have provided (whether U.S. mail, or if I agree, e-mail).

I wish to have the following restrictions amendment option to the use or disclosure of my health information: ___________________________

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via FAX.

I fully understand and (Please circle) ACCEPT / DECLINE the terms of this consent.

Responsible Party / Patient Signature: ____ Date: __________________

FOR OFFICE USE ONLY
( ) Consent received by _______ and added to the patient's medical record on ______/______/______.
( ) Consent refused by patient, and treatment refused as permitted.

FINANCIAL POLICY

West Orange Orthopaedics is committed to providing you, with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

MINORS (Under 18) MUST BE ACCOMPANIED BY AN ADULT: The parent or legal guardian accompanying a minor is responsible for payment of the charges incurred. If the child has a legal guardian, we must have proof of guardianship. If a child is visiting with family or friends out of state, we must have a notarized consent from the parents prior to rendering treatment to minor. I understand disputes regarding child/medical support are between myself and any other party involved.

INSURANCE: West Orange Orthopaedics will file your insurance providing we are able to verify your coverage prior to time of service. If we file your insurance, you must pay your percentage of total charges at the time of service. If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance.

HMO'S OR INSURANCE POLICIES THAT REQUIRE REFERRALS / AUTHORIZATIONS: I understand it is my responsibility to obtain my authorizations/referrals in writing and to bring them to the office for my appointments. I understand it is my responsibility to keep track of how many authorizations/referrals I have been given and when they expire, as well as what diagnosis the authorizations/referrals are for. **I understand if I come to my appointment without the authorization/referral and/or co-payment, I will be rescheduled.**

****APPOINTMENTS: If you cannot attend a scheduled appointment, we require a twenty-four hour cancellation notice. If you do not notify us within twenty-four hours,**
There will be a $25.00 charge and must be paid before any future appointments are made.

ACCEPTED METHODS OF PAYMENT: CASH, CHECKS, MONEY ORDER, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

I understand **COPAYS, DEDUCTIBLES AND COINSURANCES ARE DUE AT TIME OF SERVICE**. I understand insurance is a contract between my insurance company and myself. West Orange Orthopaedics will **not** become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. I understand if I need a special itemization, this request must be in writing with original signature along with photo ID. I understand West Orange Orthopaedics charges a service fee for itemizations due at time of pick up or prior to mailing. I understand West Orange Orthopaedics has a service charge for returned checks.

I hereby instruct and direct my insurance company(s) to pay by check made out to: West Orange Orthopaedics, 596 Ocoee-Commerce Parkway, Ocoee, FL 34761 or if my current policy prohibits direct payment to the doctor, I hereby instruct and direct my insurance company to make out the check to me and mail it as follows: West Orange Orthopaedics, 596 Ocoee-Commerce Parkway, Ocoee, FL 34761 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment within 45 days.

A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize West Orange Orthopaedics to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I give my consent to receive treatment from West Orange Orthopaedics for myself and/or the person named above, and take full responsibility for the charges incurred.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FORM:

I, ____, am giving West Orange Orthopaedics consent to release the below specified
(Print Patient Name)
Personal Health Information to persons on my behalf until I have completed an update of this form making any changes.

If you do not wish anyone to have info, please complete with N/A Authorized Person's Name & Relationship **Will also be considered your emergency contacts**	Identifier 1 Ex: Date of Birth	Phone Number	Confirm, Make, Reschedule or Cancel My Appointments	Leave Messages for Doctor and/or Discuss My Rx's, Tests, DME	Discuss Work Status	Discuss Billing Issues Including Diagnosis
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO

I further understand my record may not always be accessible at the time of the phone call and West Orange Orthopaedics must have time to locate my file in order to verify the caller's identifiers prior to confirming or denying release of any information.

I fully understand and (Please circle) ACCEPT / DECLINE the terms of this consent.

Responsible Party / Patient Signature: ____ Date: ______________

FOR OFFICE USE ONLY

( ) Consent received by ________ and added to the patient's medical record on ______/______/______.

( ) Consent refused by patient, and treatment refused as permitted.

**** IF YES OR NO IS NOT CIRCLED = NO****