Name:
DOB:
Age:
Chart: Date:

CONSENT TO INSURANCE BILLING AND INFORMATION PRIVACY PERMISSIONS

I. NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been offered a copy of Advanced Center for Orthopedics' Notice of Privacy Practices.

II. MEDICATION HISTORY REQUESTS
I authorize Advanced Center for Orthopedics to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

III. AUTHORIZATION TO USE EMAIL ADDRESS
I authorize Advanced Center for Orthopedics to use the email address provided below for patient communication purposes.

EMAIL ADDRESS: _____

IV. AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FRIENDs AND/OR FAMILY MEMBERS
I authorize Advanced Center for Orthopedics to disclose information concerning my illness/accident to the following people:

NAME AND RELATIONSHIP OF PERSON(s)

_____ _____

V. ASSIGNMENT OF INSURANCE PAYMENTS AND GUARANTEE OF PAYMENT
I authorize Advanced Center for Orthopedics to furnish information to insurance carriers (As listed below) concerning this illness/accident, and I irrevocably assign to the physician/organization all payments for medical services rendered. I understand that I am financially responsible for all charges that are not covered by insurance.

Insurance Carriers: _____ _____

VI. MEDICARE AUTHORIZATION
I certify that the information given by me in applying for payment under Title 18 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or related Medicare claims. I request payment of authorized benefits be made in my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment. I understand that I am responsible for payment of any health insurance deductibles and co-insurance.

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL

I have read this form, or have had it read to me, and it has been explained to my satisfaction. My Signature below acknowledges my understanding and agreement with the statements set forth in each of the paragraphs I-VI above.

_____ _____
PATIENT SIGNATURE WITNESSED BY

_____
SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE

_____
DATE