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 and Plastic Surgery's Notice of Privacy Practices.

II. MEDICATION HISTORY REQUESTS

I authorize Advanced Center for Orthopedics and Plastic Surgery 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 and Plastic Surgery 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 and Plastic Surgery 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 and Plastic Surgery 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.

VII. CONSENT TO WIRELESS TELEPHONE CALLS

If, at any time, I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify this office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging or by any other form of electronic communications from this office, affiliates, contractors, servicers, clinical providers, attorneys, or it agents including collection agencies.

VIII. CONSENT FOR AI DICTATION □ **Decline consent for AI dictation**

Your provider may be using an AI Scribe technology. This is an Artificial Intelligence tool that assists during patient vists by creating clinical notes based on conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. This tool does not interact with you directly. It merely listens to the conversation and converts voice to text in a typed summary. This note is then reviewed, approved, and edited by your provider. We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

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-VIII above.

_____ _____

PATIENT SIGNATURE WITNESSED BY

_____ _____

SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE DATE