ORTHOPAEDIC ASSOCIATES OF OSCEOLA CONSENTS/AUTHORIZATIONS

Consent for Treatment & Medical Release Authorization: I hereby consent to treatment for myself, my child, or for whom I am the legally authorized representative. I authorize Orthopaedic Associates of Osceola (OAO) to release my protected health information (PHI) to any referring physician, other health care providers, hospitals and medical facilities, to my insurance carriers for the purpose of treatment, payment, and health care operation. I understand that this PHI may include reference to , psychiatric care, alcohol and/or drug abuse, and results of tests for all infectious diseases including AIDS/HIV. I furthermore authorize OAO and staff to discuss my PHI in the presence of the family and visitors that accompany me during my visits.

Signature of Patient or Authorized Representative: _____ Date: _____

Financial Policy & Assignment of Insurance Benefits: Payment for medical services is the responsibility of the patient or the authorized representative. Our office will file for insurance benefits for plans in which we **participate**. For any insurance plans that we do not participate with and are considered **non-participating/out-of-network providers**, services rendered will not be billed to the insurance. It is your responsibility to ensure that you provide us with your correct insurance information and any referrals for care that are required. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. I hereby assign and authorize payment to Orthopaedic Associates of Osceola (OAO) of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, personal injury protection (PIP) benefits, and other medical payment coverage for which I am entitled. Please understand that your insurance policy is basically a contract between you and your insurance company. This assignment will remain in effect until revoked by me in writing. I authorize OAO to release all information necessary to secure payment of insurance benefits. **I understand that I am financially responsible for all charges whether or not paid by said insurance(s)**. For your convenience, we accept Visa, Master Card and Discover.

Signature of Patient or Authorized Representative: _____ Date: _____

Acknowledgement of Receipt of Privacy Rights: By signing below I acknowledge that I have read and had the opportunity to ask questions concerning Orthopaedic Associates of Osceola (OAO)'s Notice of Privacy Practices. This is to acknowledge that you have authorized us to:

**Contact me by any telephone numbers, email addresses, or other contact points provided by me, by the use of any automatic dialing system, pre-recorded forms of voice/messaging systems, email, telephone, cell phone, or text messages for reasons related to the services or payment for services I received at OAO.

**Please name the individuals with whom we can discuss all aspects of your protected health information (PHI):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ I **do not** authorize any information to be released to anyone other than myself.

**I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) OAO staff can utilize to leave a message for you:

_____ _____ _____

**I have the right to revoke this consent in writing at any time except to the extent that OAO has already made disclosures in reliance upon my prior consent.

Signature of Patient or Authorized Representative: _____ Date: _____