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

I, _____ (please print), understand that as part of my healthcare, American Orthopedics, Inc. 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 or 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 diagnosis 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 health care operations such as assessing quality and reviewing the competence of health care professionals

I have been given a Notice of Privacy 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 this 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 understand that American Orthopedics, Inc. 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 that American Orthopedics, Inc. 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 American Orthopedics, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

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

_____

I wish to be contacted in the following manner:

		OK to leave message	OK to leave call-back number ONLY
Home phone		☐	☐
Cell phone		☐	☐
Work phone	( ) _____		
Email	_____		

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 disclosures via fax and/or other electronic transmission. I understand and accept the terms of this Consent.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date

Financial Arrangements & Medical Insurance

AMERICAN ORTHOPEDICS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED unless payment arrangements have been approved in advance by our Finance Manager. We accepted CASH, CHECKS, and MAJOR CREDIT CARDS.

The invoice you receive at your visit provides all the information you will need to file a claim for reimbursement from your insurance company. We will be happy to assist you in processing your insurance forms for reimbursement. Any such request must be accompanied by a completed insurance form for each visit.

In some cases, we will file your insurance claims for you. However, you are responsible for all co-payments and deductibles.

***** WE CANNOT ACCEPT ASSIGNMENT FOR CLAIMS OF LESS THAN $100.00 *****

***** A FEE OF $25.00 WILL BE ASSESSED FOR EACH RETURNED CHECK *****

Our fees for service are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowable determined by each carrier.

This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as "Usual, Customary and Reasonable" fee for this region. Thus, our fees are considered usual, customary and reasonable by most insurance companies. This statement does not apply to companies who reimburse based on an arbitrary "Schedule" of fees, which bears no relationship to the current standard and cost of care in this area. **NOT ALL SERVICES WE PROVIDE ARE COVERED BENEFITS.** Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical care providers, **our relationship is with you, not your insurance company.** As a service to you, our office will submit claims to your insurance company. However, you are ultimately responsible for the account. If temporary financial problems arise that may affect timely payment of your account, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us for assistance.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

Patient Signature (or Parent/Legal Guardian if a minor) _____ Date _____