ADVANCED ORTHOPAEDICS & SPORTS MEDICINE
OFFICE POLICY

AUTHORIZATION TO TREAT:

I hereby grant permission to the authorities of Advanced Orthopaedics and Sports Medicine and the medical staff to perform such medical and/or surgical procedures they deem necessary. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s). I understand that should I leave the center without written consent of my attending physician, I hereby relieve said physician and the center of all responsibility of my action.

TELEPHONE CONSUMER PROTECTIONS ACT (TCPA):

I agree that the facility, Advanced Orthopaedics & Sports Medicine or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility, may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to cellular/wireless telephone numbers, which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

FINANCIAL POLICY:

I have read and understand the financial policies, procedures and authorizations of Advanced Orthopaedics & Sports Medicine to include payment methods, uninsured accounts, financial responsibility resulting from insurance, insurance policy provisions, diagnostic and laboratory testing, collection activities, service fees, economic hardship, discharge of patient, out-of-network, ERISA plans, final cost of services, and authorizations to include assignment of benefits, record usage provision, consent for medical treatment, consent to use and disclosure of health information for treatment, payment and operations, appointed representative, and notice of privacy practices. I understand that these policies, procedures and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization in place.

ASSIGNMENT OF BENEFITS:

I certify that the information I have given to Advanced Orthopaedics & Sports Medicine is true and correct to the best of my knowledge. I promise to pay to Advanced Orthopaedics & Sports Medicine all charges and expenses for services provided to me by Advanced Orthopaedics & Sports Medicine in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Advanced Orthopaedics & Sports Medicine. I will personally be responsible for all charges for services that are not covered by my insurance carrier.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE
HIPAA

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

❑ I hereby **authorize** the release of medical information (by telephone, mail or otherwise) by physicians and staff of Advanced Orthopaedics and Sports Medicine to: *(please list name and relationship)*

Name/Relationship	**Address/Phone Number**
_____	_____
_____	_____
_____	_____

❑ **I DO NOT** authorize the release of medical information to my family members.

CONSENT FOR RELEASE OF PHOTOS/RADIOGRAPHS/VIDEOS FOR WEBSITE PUBLICATION:

❑ I hereby give permission to Advanced Orthopaedics and Sports Medicine to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, and/or research purposes as well as to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied. *I understand that no identifying information will be used*

❑ **I DO NOT consent** to the use of any pictures/videos/radiographs obtained during my treatment

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

❑ I acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

*** You may refuse to sign this acknowledgment***

❑ I refuse to sign this acknowledgement

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name:_____ Relationship to patient: _____

Responsible Party Signature: _____ Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because _____