ASSOCIATES IN ORTHOPEDICS, PC

Patient Confidentiality Agreement

I,________________________________, understand that as part of my health care, Associates In Orthopedics, PC originates and maintains health records describing my health history, symptoms, examination and tests 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 were actually provided.**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I understand and have been provided with 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 request restrictions as how my health information may be used or disclosed to carry out treatment, payment, or health care operations.**

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

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I understand that Associates in Orthopedics, PC 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.

I further understand that Associates in Orthopedics, PC reserves the right to change their notice and practices, and prior to implementation will send a copy of any revised notice to the address I've provided.

I understand that as part of Associates in Orthopedics, PC 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. I also understand that it is the policy of Associates in Orthopedics, PC to call patients regarding their appointments and to leave messages on patients' answering machines. I agree to this form of communication, unless stated above.

I understand and accept / decline the terms of this consent.

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Patient/Guardian Signature **Date**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PHYSICIAN OR GROUP INDICATED ON THE CLAIM. I recognize and accept personal responsibility for any balance or fee not covered by my Insurance Carrier.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment and waive any right to revoke this authorization as it relates to processing Insurance Claims.

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Signature **Date**

Updated March 2015