Arthritis & Osteoporosis Center

PATIENT'S CONSENTS

Financial policy Date X__________________

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. The only exception to this an approved worker's compensation claim, and that should my worker's compensation status be reversed, that I am then responsible for the entire bill. I understand that the fees are bad on treatment received and have no bearing on outcome. I also understand there may be a charge for appointments missed or cancelled less than 24 hours prior to my appointment time.

I understand ARTHRITIS & OSTEOPOROSIS CENTER INC.'s Financial policy – Signature X_______________

Authorization to Pay for Professional Services Rendered

I hereby authorize payment directly to ARTHRITIS & OSTEOPOROSIS CENTER INC. of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company to ARTHRITIS & OSTEOPOROSIS CENTER INC.

I understand ARTHRITIS & OSTEOPOROSIS CENTER INC.'s professional services rendered policy -Signature X__________________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of a notice of privacy practices from ARTHRITIS & OSTEOPOROSIS CENTER INC.

I understand that ARTHRITIS & OSTEOPOROSIS CENTER INC. may at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

X____ Notice given to patient X___ Patient declined copy of notice Signature – X_________________

Note to office staff: If unable to obtain acknowledgement of receipt of Notice of Privacy Practices, please disclose reason and signature at the end of this page.

Authorization to Leave Messages in my Absence

I give ARTHRITIS & OSTEOPOROSIS CENTER INC. permission to leave a message on my answering machine or with the following family members regarding reports, or blood work in my absence if I am not home when they call.

Initials__________________________ Leave information with: ________________________

The above authorizations will remain in effect until revoked by me in writing. A photocopy of this shall be considered as effective and valid as the original

Consent to Treatment

I consent to general treatment, medical procedures, and medications prescribed by ARTHRITIS & OSTEOPOROSIS CENTER INC. I understand the physician's and staff of ARTHRITIS & OSTEOPOROSIS CENTER INC. will not discuss my health information with my family or friends unless I expressly authorize them to do so. X____________________

Authorization to Request Medical Records

I hereby authorize __________________ to release copies of my medical records to ARTHRITIS & OSTEOPOROSIS CENTER INC. for the purpose of evaluation and treatment of my current condition.

Authorization to Release Medical Records

I hereby authorize ARTHRITIS & OSTEOPOROSIS CENTER INC. to release any medical information, including confidential information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. X_________________________

ARTHRITIS AND OSTEOPOPROSIS CENTER, INC

PATIENT AUTHORIZATION FORM

Arthritis & Osteoporosis Center, Inc. Is required to obtain written authorization before using or disclosing protected health information.

Emergency Contact Name(s): ____

Relationship: ____

Contact Phone Number(s): ____

I consent to the following:

When calling my home, the practice may leave a message:

ON MY ANSWERING MACHINE: YES____ NO____

I PREFER YOU LEAVE A MESSAGE ONLY WITH ME: YES____ NO____

MAY CALL MY PLACE OF BUSINESS: YES____ NO____ PHONE NUMBER: ________________

I authorize the Arthritis & Osteoporosis Center to speak to the following individual(s) regarding my billing/financial information:

____________________________________Relationship________________________

____________________________________Relatiionship________________________

____

Patient Name (print)

Date: ______________________

*The patient has the right to revoke the above authorizations at any time in writing. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by this rule. The practice will not condition treatment or payment on the individual's provider authorization for the requested use or disclosure.