

CONSENT FOR INVOLVEMENT IN CARE

Orthopaedic Surgical Associates, LLC

In order to comply with specific rules regarding HIPAA, we ask that our patients complete and sign this privacy and security of health information.

Unless this form is completed, we cannot talk to anyone but you regarding your medial care. If precriptions are written for you, no one other than yourself can pick them up, and we cannot speak to anyone regarding billing information on your account.

BILLING AND PAYMENT INFORMATION

I, _____, hereby authorize Orthopaedic Surgical Associates billing department to speak to the person(s) listed below regarding my billing and payment information.

1. _____ relationship to patient _____
2. _____ relationship to patient _____

MEDICAL & PRESCRIPTION INFORMATION

I, _____, hereby authorize Orthopaedic Surgical Associates to release medical information and prescriptions that need to be picked up on my behalf to the person(s) listed.

1. _____ relationship to patient _____
Medical Information Only _____ Prescriptions Only _____ Both Medical & Prescriptions _____
2. _____ relationship to patient _____
Medical Information Only _____ Prescriptions Only _____ Both Medical & Prescriptions _____

PATIENT CONTACT

I, _____, hereby authorize Orthopaedic Surgical Associates and staff to contact me regarding appointments, prescriptions, and account information by the following methods.

- | | Yes | No | N/A |
|--|-----------------------------|-------|-------|
| 1. Home Telephone _____ | _____ | _____ | _____ |
| 2. Work Telephone _____ | _____ | _____ | _____ |
| 3. Cellular Phone/Text _____ | _____ | _____ | _____ |
| 4. E-mail _____ | _____ | _____ | _____ |
| 5. Leave Voice Mail _____ | _____ | _____ | _____ |
| 6. Paperless Billing Only Text _____ E-mail _____ Both _____ | Paper Statements Only _____ | | |
| Both Electronic and Paper Statements _____ | | | |

I understand and assume responsibility of notifying Orthopaedic Surgical Associates whenever the listed information changes. I understand this release **excludes**; insurance companies, attorneys and other health care providers.

Patient Signature

Date

