CONSENT TO USE PROTECTED HEALTH INFORMATION &
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Instructions / Rights of Patient

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1. Protected Health Information ("PHI") may be used or disclosed to carry out treatment, payment or Health Care Operations.
2. You have the right to read and inspect the Notice of Privacy Practices for this health care facility prior to signing this form. The Notice of Privacy Practices may change at any time; therefore you should request and review a new Notice of Privacy Practices if you have not done so recently.
3. You have the right to place restrictions on how your PHI may be used or disclosed in the space provided below.
4. You have the right to revoke this Consent by sending a written notice, indicating the date and subject matter or other information that will reasonably identify this Consent.

Consent for Release of Personal Health Information:

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Consent and that I am legally competent to sign this Authorization on behalf of myself or the Patient. I authorize Folsom Orthopaedic Surgery to use or disclose the PHI to carry out treatment, payment or Health Care Operations.

_____ _____/_____/_____
(Authorized Signature) (Date)

_____
(Relationship to Patient)

I authorize any medical information to be released to my husband/wife _____,

or to _____.
(Family member or friend)

Office Policies & Fees

During Your Office Visit:

- Co-pays are due at the time of visit and will be collected upon check in.
- Account balances will also be addressed, even if a statement hasn't been sent.
- For high deductible plans you will be asked for a deposit towards treatment at each visit.
- Out-of-network plans are considered private pay and will be collected in full at each visit.
- We do not bill supplemental accident insurance plans.

Surgery Estimates:

- Should your physician recommend surgery, you will be provided with an estimate for the surgeon fees. Any out of pocket costs will be requested in full as a deposit prior to the procedure.

Collection Accounts:

- **Any account sent to a collection agency will be withdrawn from any further care by any provider in this office_____**
(Initial)

Returned checks will be assessed a $25.00 fee.

Insurance forms or disability forms are assessed a fee of $15.00 for each form requiring completion by a provider. This fee is due before the forms will be mailed/released.

Medication refills require 24 hours to be completed. Please call your pharmacy first; they will submit the information to us directly. Refill requests will not be done on Friday, Saturday or Sunday, please plan ahead.

Copying of medical records will be assessed a fee of $15.00 for chart copies, $10.00 per x-ray sheet.

I hereby agree that failure to adhere to the above office policies may result in dismissal from this medical practice.

_____ _____/_____/_____
(Signature) (Date)