

FALMOUTH ORTHOPAEDIC CENTER

**GENERAL CONSENT FOR TREATMENT*CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION
ASSIGNMENT OF BENEFITS*PATIENT RESPONSIBILITY FOR PAYMENT**

A. PATIENT (OR AUTHORIZED REPRESENTATIVE'S) CONSENT TO MEDICAL TREATMENT

*I hereby request and give my permission for the health care providers at Falmouth Orthopaedic Center to provide medical evaluation and treatment, including but not limited to x-ray examinations, injections and aspirations, and laboratory examinations as they deem medically indicated.

*As a parent or legal guardian/representative I give full consent to the health care providers at Falmouth Orthopaedic Center for office evaluation and treatment of the child or person for whom I am the guardian.

*I consent to the evaluation and treatment of adolescent children without the presence of an adult for routine follow up care.

*I understand that separate consents will be requested for surgical procedures.

*I understand that I can revoke this consent at any time up until the time that the treatment is started.

B. CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

*I consent to Falmouth Orthopaedic Center’s disclosure of PHI, which may include HIV status, to other health care practitioners and facilities that are involved in providing medical services to me and to my family and close friends who are providing me with emotional support as I receive medical services, unless specifically limited. Also, I consent Falmouth Orthopaedic Center’s disclosure of PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

*I have received a copy of Falmouth Orthopaedic Center’s Notice of Privacy Practices that provides a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice of Privacy Practices before signing this consent. I acknowledge that Falmouth Orthopaedic Center reserves the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.

C. PAYMENT AND/OR ASSIGNMENT OF BENEFITS

*I understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I am also responsible for those charges not covered by my insurance such as co-insurance, deductibles, co-payments, or evaluations or treatment that are not covered benefits.

*I authorize my health insurance carrier(s) or other third parties who are responsible for paying for my health care to pay my insurance benefits directly to Falmouth Orthopaedic Center.

I understand that this document remains in effect for as long as I continue to receive care at Falmouth Orthopaedic Center unless specifically rescinded in writing.

D. SIGNATURE

Patient Signature

Patient Printed Name

Date

If the signature is of an authorized representative, the authorized representative is to complete and certify that the following is true: I am legally authorized to provide consent on behalf of the patient listed above.

Signature Authorized Representative

Printed Name Authorized Representative

Date

Relationship to Patient