

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I **AUTHORIZE** Valley Orthopaedic Specialists, LLC to release my health insurance companies and its agents any medical information needed to process my medical claim and release medical information to participating providers as needed. I understand that my records may contain information regarding diagnosis or treatment of specific diseases including psychiatric, drug / or alcohol abuse, sexually transmitted diseases, HIV test results, and related information. I give my specific authorization for these records to be released. _____

Initials

CONSENT FOR TREATMENT

I consent for medical treatment for myself *or* for the patient who I am a parent or legal guardian. I also understand that if the patient is a minor (under the age of 18 yrs old), a parent or a legal guardian must attend all appointments. _____

Initials

ASSIGNMENT OF MEDICAL BENEFITS / GUARANTEE OF FINANCIAL RESPONSIBILITY

I request that payment of authorized medical benefits be made directly to **VALLEY ORTHOPEDIC SPECIALISTS, LLC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that **I AM FINANCIALLY RESPONSIBLE** for all charges whether or not paid for by said insurance. In the event that I fail to pay charges due, and **VALLEY ORTHOPEDIC SPECIALISTS, LLC** refers my account to collection, I agree to pay costs of collection including a reasonable attorney fee. _____

Initials

For **MEDICARE PATIENTS** this applies to the **SOCIAL SECURITY ADMINISTRATION, THE CENTER for MEDICARE and MEDICAID SERVICES** or its intermediaries or carriers.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

“I hereby acknowledge that I have received a copy of this practice’s **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.” _____

Initials

Patient /Parent or legal Guardian (please print)

Date

Patient /Parent or legal Guardian Signature

Date