

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS**

I, _____, understand that as a part of my health care, Orthopaedic Specialties of Tampa Bay, P.A. originates and maintains paper and/or electronic records and radiographs describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with the Orthopaedic Specialties of Tampa Bay, P.A. Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I further understand that Orthopaedic Specialties of Tampa Bay, P.A. reserves the right to change their Notice of Privacy Practices in accordance with the regulations outlined in the Federal Register. Should Orthopaedic Specialties of Tampa Bay, P.A. change their notice, I may request a copy of any revised notice.

I request the following restrictions to use or disclosure of my health information: _____

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operations. Unless you so designate, we will not even be allowed to carry out simple tasks such as scheduling of appointments with anyone other than yourself/patient. Please check all that apply and supply names:

- Spouse: _____
- Child or Children: _____
- Parent: _____
- Grandparents: _____
- Siblings: _____
- Power of Attorney: _____
- Legal Guardian: _____
- Friend: _____
- Other (Please include relationship): _____

May we leave messages at your **home** using the doctor's or practices name? **Yes** **No**

May we leave messages on your **cell** phone using the doctor's or practices name? **Yes** **No**

May we leave a message at your **work** using the doctor's or practices name? **Yes** **No**

Do not leave a message

(Messages will be of a non-sensitive nature such as reminders for appointment referrals, etc.)

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and Accept / Decline (please circle one) the information of this consent.

Signature of Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

_____/_____/_____
Date



HIP & KNEE RECONSTRUCTIVE CENTER • CENTER FOR SPINAL DISORDERS • FOOT & ANKLE CENTER • SPORTS MEDICINE
GEORGE A. MORRIS III, M.D. • MICHAEL R. PIAZZA, M.D. • RICHARD V. ABDO, M.D.
W. ALLEN HUGHES, M.D. • J. BYRON DAVIDSON, D.O. • HOWARD L. SCHUELE, M.D. • ANTHONY L. MARCOTTE, D.O.

PRACTICE FINANCIAL POLICY

1. **Co-payments are collected as you check in for your appointment.**
2. **All patient responsibility fees are due at the time services are rendered. Please make sure that you obtain a receipt for all cash payments. For your convenience we also accept Visa and Master Card.**
3. **If you need special financial consideration, please speak with one of our billing specialists prior to seeing the doctor.**
4. **If you belong to an insurance plan that requires prior authorization from a primary care physician or insurance company, it is your responsibility to make sure that authorization has been issued. If prior authorization is not issued from your primary care physician or insurance company, you will be personally responsible for the charges incurred.**
5. **If you belong to an insurance plan with which we do not participate you will be personally responsible for payment in full at the time services are rendered. We will gladly assist you with the filing of claim forms for your reimbursement.**
6. **If you are unable to pay in full at the time services are rendered we will require a signed payment agreement, guaranteeing payment.**
7. **If your treatment is related to an auto accident and your regular health insurance is through a managed care plan, you must still obtain an authorization from your primary care physician or insurance company for treatment. If no authorization is obtained your managed care plan will not pay after your PIP benefits are exhausted, and you will be held responsible.**
8. **In the case of divorced parents, responsibility for payment of a child's medical expenses incurred shall be that of the parent bringing the child in for treatment. In no case shall the other parent be billed unless financial arrangements have been made with that parent and we have legal documentation stating that they are the responsible party.**
9. **There will be a minimum charge of \$25.00 for checks returned for non-sufficient funds. After receipt of a NSF check we reserve the right to require cash or money order for payment.**
10. **In the event that you fail to pay patient responsibility account balances, and we are forced to place your account with our attorney for collection, you will pay the attorney fees and other costs we incur in collecting the amounts owed by you.**

This is the philosophy of our practice, however, we do reserve the right to amend this policy at any time.

Signature

Date

Witness

Date