

Somerset Orthopaedics, Inc.

CONSENT TO TREAT, RELEASE INFORMATION TO INSURANCE COMPANIES, ASSIGNMENT OF BENEFITS, AND HIPPA CONSENT

PATIENT NAME (please print): _____

Consent To Treat

I consent to treatment necessary for the care of the patient indicated on this form. I understand this facility may employ physician extenders (physician assistants).

Signature (Patient, Parent, or Guardian)

Date

Consent to Release Information to Insurance Companies and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Signature (Patient, Parent or Guardian)

Date

I hereby authorize Somerset Orthopaedics, Inc. to apply for benefits on my behalf for covered services rendered by the attending physician or by his/her order. I request that payment from my insurance company be made directly to Somerset Orthopaedics, Inc. I certify that the information I have reported with regard to my insurance is correct. I understand I am financially responsible for this account. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature (Patient, Parent or Guardian)

Date

Consent to Release Information

As stated in our Notice of Privacy Practices, we may use or disclose information about you in order to conduct routine office operations (eg. appointment reminders, general communications). To request restrictions, other than provided for below (**please check those that apply**), please provide your request in writing to the office administrator for consideration.

- Do not leave messages on home phone
 Do not call work number
 Do not speak to family members

Permission to speak only with family member(s) listed below;
Please provide name, relationship to patient, and phone number.

HIPPA Consent (Patient Privacy Law)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent; a copy will be provided to you upon request. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by calling Public Relations at 814-443-5221.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature (Patient, Parent or Guardian)

Date