ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

OFFICE POLICY

AUTHORIZATION TO TREAT:

I hereby grant permission to the authorities of Advanced Orthopaedics and Sports Medicine and the medical staff to perform such medical and/or surgical procedures they deem necessary. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/ treatment(s). I understand that should I leave the center without written consent of my attending physician, I hereby relieve said physician and the center of all responsibility of my action.

TELEPHONE CONSUMER PROTECTIONS ACT (TCPA):

I agree that the facility, Advanced Orthopaedics & Sports Medicine or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001 and related state regulations and statutes. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

PATIENT AUTHORIZATION TO OBTAIN SUMMARY PLAN DESCRIPTION & 5500 FORM :

I hereby direct you to forward to Advanced Orthopaedics & Sports Medicine the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. **Summary Plan Description (SPD)**
2. **5500 Form (Plan Annual Report)**
3. **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address immediately:
Billing Manager
Advanced Orthopaedics & Sports Medicine
11800 FM 1960 W Rd,
Houston, TX 77065

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

FINANCIAL POLICY

FINANCIAL POLICY:

I have read and understand the financial policies, procedures and authorizations of Advanced Orthopaedics & Sports Medicine to include payment methods, uninsured accounts, financial responsibility resulting from insurance, insurance policy provisions, diagnostic and laboratory testing, collection activities, service fees, economic hardship, discharge of patient, out-of-network, ERISA plans, final cost of services, and authorizations to include assignment of benefits, record usage provision, consent for medical treatment, consent to use and disclosure of health information for treatment, payment and operations, appointed representative and notice of privacy practices.
I understand that these policies, procedures and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization in place.

ASSIGNMENT OF BENEFITS:

I certify that the information I have given to AOSM is true and correct to the best of my knowledge and that I am responsible for keeping it updated. I promise to pay to AOSM all charges and expenses for services provided to me by AOSM in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to AOSM. I will personally be responsible for all charges for services that are not covered by my insurance carrier. I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and their Authorized Representatives. I agree to return any claim checks received from my health plan directly to Advanced Orthopaedics within three (3) days of receipt. I will endorse the check; Write Payable to "Advanced Orthopaedics and Sports Medicine" and "For deposit only" under it. Send all correspondence to : Billing Manager, Advanced Orthopaedics and Sports Medicine, 11800 FM 1960 W Rd, Houston, TX 77065
I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including filing medical claims, appeals and grievances, institute litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims.
I understand I can revoke this authorization in writing at any time.
A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

❑ I hereby **authorize** the release of medical information (by telephone, mail or otherwise) by physicians and staff of Advanced Orthopaedics and Sports Medicine to (please list name and relationship)

Name/Relationship	**Address/Phone Number**
_____	_____
_____	_____
_____	_____

❑ I **DO NOT** authorize the release of medical information to my family members.

HIPAA

CONSENT FOR RELEASE OF PHOTOS/RADIOGRAPHS/VIDEOS FOR WEBSITE PUBLICATION:

❑ I hereby give permission to Advanced Orthopaedics and Sports Medicine to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.
I understand that no identifying information will be used

❑ I **DO NOT consent** to the use of any pictures/videos/radiographs obtained during my treatment

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

❑ I acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

*** You may refuse to sign this acknowledgment***

❑ I refuse to sign this acknowledgement

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relationship to patient : _____

Responsible Party Signature: _____ Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because: _____