



I acknowledge that I have received a copy of the privacy policies of Orthopedic Associates of SW Ohio

Patient Signature

Date

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of OASWO. I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to OASWO using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that OASWO reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying OASWO in writing, except to the extent that OASWO has taken action in reliance on my consent.

MEDICARE PATIENTS ONLY-PLEASE COMPLETE THIS SECTION

- 1. Are you currently working? Yes No
If yes, employer? _____
- 2. Do you have insurance through your employer? Yes No
- 3. Is your spouse currently working? Yes No
If yes, employer? _____
- 4. Do you have insurance through your spouse's employer? Yes No
- 5. Is your visit related to an accident or injury? Yes No
If yes, do you have any other insurance responsibilities for this bill? Yes No

If you answered yes to any questions above, please provide insurance information to the staff.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to OASWO any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to OASWO of all insurance benefits and agree to pay any balance due.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's authority to act for the patient.