Notice of Privacy Practices Acknowledgment Receipt

STEINDLER ORTHOPEDIC CLINIC

Account #: _____

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Steindler Orthopedic Clinic's (SOC) Notice of Privacy Practices. Steindler Orthopedic Clinic is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you are aware of SOC's Notice of Privacy Practices posted at Steindler Orthopedic Clinic, PLC and that you may receive a copy of the Notice upon request.

Patient Name: _____ **Date of Birth:** _____
(please print)

_____ _____
Signature of Patient or Patient Representative **Date**

If signed by Patient Representative, print name and state authority to act on behalf of the patient: _____

As noted on the SOC Notice of Privacy Practices, your medical and financial information may be shared with others only for certain specific purposes, such as for treatment, payment and health care operations. Please complete the back side of this form to specifically designate the individual(s) you authorize SOC to contact or share your medical and financial information with on your behalf.

CONSENT FOR CARE AND TREATMENT: I understand that I have the right to be informed of the nature and purpose of all services provided to me at Steindler Orthopedic Clinic, PLC (SOC) as well as alternatives, risks, consequences or complications of such services. I consent to the routine examination, treatment, testing, and other routine procedures and administration of medication that may be considered necessary and advisable by SOC health care professionals.

RELEASE OF INFORMATION: In order to assure proper quality and continuity of care, I consent to the release by SOC of my health records and medical information about me (including information, if any, about substance abuse, mental health, HIV/AIDS or other health issues to the extent permitted by law) to physicians, providers and staff as necessary for treatment, reviewing quality of care and for SOC operations, so long as the release is in compliance with applicable law. A more complete description of my rights regarding my health information can be found in the SOC Notice of Privacy Practices, which is available upon request.

PAYMENT AND INSURANCE CONSENT: I request that payment be made to SOC on my behalf for any services furnished to me by SOC. I understand that I am responsible for services that are not covered by my insurance. I authorize SOC to release any information needed to secure payment to any governmental or third party responsible for payment, including Medicare and it's agents, any insurance company and any other governmental or private payor.

STATEMENT OF NONDISCRIMINATION: Steindler Orthopedic Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

SOC Internal Use Only

An attempt was made to obtain an acknowledgment of receipt of the Notice of Privacy Practices on: (date) _____

The acknowledgment was not obtained because: _____

_____

SOC staff member name: _____ Signature: _____ Date: _____

Contact Form

STEINDLER ORTHOPEDIC CLINIC

Responsible Billing Party for Young Adults (Age 18-26)

Young adults age 18-26 are **legally** responsible for any balance not covered by insurance, even though they may be covered under their parent's insurance plan. We are aware that some parents may still be willing to financially support their young adult. Please indicate if the young adult age 18-26 should receive the billing statement.

YES or **NO** (circle one)

If NO: Please list the parent's **name, date of birth, and address** where the billing statement will need to be sent.

_____

_____

_____ _____

Signature of Responsible Billing Party **Date**

I allow Steindler Orthopedic Clinic (SOC) to contact and/or share my information with the following individual(s) so that they may be able to assist with my care or with payment for my care:

Primary Contact Name (please print)**:** _____

Relationship to Patient: _____ **Phone:** _____

I allow SOC to share my medical information with this individual. ☐ **Yes** ☐ **No**

I allow SOC to share my financial information with this individual. ☐ **Yes** ☐ **No**

Other Contact Name (please print)**:** _____

Relationship to Patient: _____ **Phone:** _____

I allow SOC to share my medical information with this individual. ☐ **Yes** ☐ **No**

I allow SOC to share my financial information with this individual. ☐ **Yes** ☐ **No**

Note that by signing below, you are giving your written consent to SOC to contact and/or share your medical and financial information with the individual(s) listed. It is your responsibility to notify SOC if you desire to make any changes to the information on this form, including in the event of a divorce or other family change. We will assume the information is up-to-date unless we are otherwise notified by you in writing. As of the date of signature below, this Contact Form replaces any SOC Information Release Forms previously signed by me.

_____ _____

Signature of Patient or Patient Representative **Date**

If signed by Patient Representative, print name and state authority to act on behalf of the patient: _____