Shoreline Orthopaedics

Consent to Treat / Acknowledgement of Receipt of Privacy Notice / Financial Policy

PATIENT NAME (Printed): _____ DOB: _____

By signing this form, I am consenting to Shoreline Orthopaedics' use and disclosure of my PHI to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this request, Shoreline Orthopaedics may decline to provide treatment to me.

Assignment of Benefits:

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the physician or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. I agree to the posted financial policy in its entirety. (Copies available upon request or on www.shorelineortho.com)

Medicare:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Shoreline Orthopaedics for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named practice any information regarding my Medicare claims under Title XVIII of the Social Security Act.

Orthopaedic Urgent Care:

I understand that if I am seen in the Orthopaedic Urgent Care that my insurance will be billed as a specialist office visit and not an urgent care visit. I understand this office is not recognized as a free standing urgent care center. I am requesting service because I need to be seen urgently due to an orthopaedic concern.

HIPAA Privacy Policy:

I acknowledge that Shoreline Orthopaedics' "Notice of Privacy Practices" has been offered and/or provided to me. (Copies posted at the office, available upon request, or online at www.shorelineortho.com). I understand that Shoreline Orthopaedics reserves the right to change this notice at any time, without warning, and will post a copy of the revised notice in the waiting areas of the office.

Patient/Legal Representation Signature: _____ **Date**: _____