



Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

<p>1. Release of Information: I authorize the disclosure of any or all of the information in my medical record to:</p> <p>a. Any person, corporation, or agency responsible for all or part of Orthopaedic Specialists of Springfield, P.C. who may be responsible for determining the necessity, appropriateness, payment, or other matters related to Orthopaedic Specialists of Springfield, P.C. treatment or services;</p> <p>b. This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.</p> <p>c. I further authorize the hospital, at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carriers.</p> <p>2. Assignment of Benefits: I assign to Orthopaedic Specialists of Springfield, P.C. and/or the independent Contract Groups named in the Notice of Privacy Practices, the benefits due me covering Orthopaedic Specialists of Springfield, P.C. services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.</p> <p>3. Medicare Patients: I authorize Orthopaedic Specialists of Springfield, P.C. to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.</p>	<p>4. Financial Obligation for Orthopaedic Specialists of Springfield, P.C. any Physician Employee of Orthopaedic Specialists of Springfield, P.C., and the Independent Contract Groups named in the Notice of Privacy Practices: I agree that I am financially responsible for payment of all amounts for services provided by the hospital and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Orthopaedic Specialists of Springfield, P.C. and my insurer, or prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.</p> <p>5. Guarantor's Responsibility: I have read and understand the financial obligation above and agree to the terms as stated.</p>
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CONSENT FOR TREATMENT: As a patient of Orthopaedic Specialists of Springfield, P.C., I agree, request and authorize my attending physician to administer such treatment as is necessary. This includes their associates and/or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary. This would also include, but not be limited to, the performance of services involving pathology and radiology.

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed:
Please check the appropriate box(es)

- Any aspect of my Health Care

 Health information only

 Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name _____ Relationship _____ Phone # _____
 Name _____ Relationship _____ Phone # _____
 Name _____ Relationship _____ Phone # _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of Orthopaedic Specialists of Springfield, P.C. sets forth the ways in which my personal health information may be used or disclosed by Orthopaedic Specialists of Springfield, P.C., and outlines my rights with respect to such information. I acknowledge that on _____ (Date),

- I received a copy of the Orthopaedic Specialists of Springfield, P.C. Notice of Privacy Practices
 I declined a copy of the Orthopaedic Specialists of Springfield, P.C. Notice of Privacy Practices
 I was previously provided a copy of the Orthopaedic Specialists of Springfield, P.C. Notice of Privacy Practices

Patient Name (print): _____ Signature: _____
 Patient DOB or SSN: _____ Relationship (if signed by other): _____