ORTHONOW

BRET SOKOLOFF, MD

Patient Name:_____Date:_____

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform the receptionist.

Consent for Medical Treatment

I authorize OrthoNow physicians and their health care team to render the evaluation and medical treatment needed. I further authorize the use of X-Rays, injections, casting, bracing or other diagnostic tests and treatment as determined necessary by my health care provider.

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by OrthoNow. I assign and authorize payments of medical insurance benefits to OrthoNow directly and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collection this account to include attorney's fees, court costs and collection agency costs in the event of default of payment of my charges. It is my responsibility to contact my insurance company and or employer to verify that OrthoNow is a participant in my insurance plan prior to treatment. OrthoNow does not accept third party liability, such as automobile insurance, pending litigation and other indirect insurance products and I am responsible for the full payment of services at the time rendered.

If my insurance plan requires a referral in order to be treated by a specialist, it is my responsibility to obtain the referral prior to being treated at OrthoNow. If a referral is required and I fail to obtain one, I will be financially responsible for any services.

OrthoNow will submit a claim to my insurance company but will require payment of any unpaid deductible, co-payments and coinsurance for the services provided in the office at the time rendered. If I am without verified health insurance or with a plan with which OrthoNow does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out of network" I am responsible for the balance.

Some insurance companies claim that certain Orthopaedic supplies that physicians prescribe for the patient's well being are not covered. I agree to pay for these supplies in the event my Insurance denies coverage.

OrthoNow accepts cash, checks, credit and debit cards. Returned checks are subject to a $35.00 processing fee.

Consent For Release Of Medical Information

I understand that I have certain rights regarding the use of my Protected Health information (PHI). These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). My signature below indicates I have been given the opportunity to read OrthoNow notice of Privacy Practices for PHI and I further understand that I can obtain a copy of this policy upon request.

I hereby authorize the release and disclosure of my PHI for treatment, payment or health care operations. I understand that any records containing my personal and medical history are the confidential property of OrthoNow. I consent to allowing OrthoNow to communicate with and exchange medical information with my Primary Care Physician and any referrals/specialists that are or may become involved in my care. This will remain in effect until I notify OrthoNow in writing of my desire to withdraw such authorization.

SIGNATURE OF PATIEN/GUARDIAN:_____DATE:_____