TOWSON ORTHOPAEDIC ASSOCIATES, INC.

Consent for Care and Treatment

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Orthopaedic Associates, Inc. to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Benefit Assignment/Release of Information

I, hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled to Towson Orthopaedic Associates, Inc.. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

Financial Policy Statement

Towson Orthopaedic Associates, Inc. bills your insurance carrier as a courtesy to you. After 60 days the balance may be due if we are not able to resolve your insurance payment. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you agree to promptly remit same to Towson Orthopaedic Associates, Inc.

The above does not apply for those patients covered by the Workers Compensation Act. However, a Workers Compensation patient may be responsible for the charges if the claim is denied.

In the event that my account is referred to a collection agency, there will be a 35% fee added to the outstanding balance.

Name of Health Insurance: _____Co-pay $ _____

I have read and fully understand the above information. I/We understand my/our responsibility for the payment of the account. I/We guarantee the payment of my/our account with Towson Orthopaedic Associates, Inc. and accept the medical care provided as consideration in full for this guarantee.

Research

We may disclose information to researchers when an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Release of Protected Health Information

To whom may we disclose PHI. (Family member(s) or friend(s))

Name: _____ Name: _____
Relationship to patient: _____ *Relationship to patient:* _____
Home Tel: _____ Home Tel: _____
Cell/Work Tel: _____ Cell/Work Tel: _____

Wireless Communication

I expressly consent and authorize Towson Orthopedic Associates, Inc. and its agents to:

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to Towson Orthopedic Associates, Inc. at any time associated with me or my account;

b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages, for any reason related to the services received at Towson Orthopedic Associates, Inc. or services received at Towson Orthopedic Associates, Inc. in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and

c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by Towson Orthopedic Associates, Inc. or services to be provided by Towson Orthopedic Associates, Inc. in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify Towson Orthopedic Associates, Inc. if any telephone number, email address or other unique electronic identifiers or modes that I provided to Towson Orthopedic Associates, Inc. change or are no longer used by me.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

Privacy of Information: *(please initial one)*

_____ I <u>ACKNOWLEDGE</u> receipt of a copy of the Notice of Privacy Practices which explains how Towson Orthopedics Associates, Inc. may use and disclose protected health information; or

_____ I <u>REFUSE</u> receipt of a copy of the Notice of Privacy Practices which explains how Towson Orthopedics Associates, Inc. may use and disclose protected health information

* Notice Towson Orthopaedic Associates, Inc. charges $15 for completing Medical Leave forms.

Patient Signature/Legal Representative _____ Date _____
Please Print Your Name _____ Date _____
Towson Orthopaedic Associates, Inc. Representative _____ Date _____