

WEST IDAHO ORTHOPEDICS AND SPORTS MEDICINE

CONSENT FOR THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights and responsibilities with respect to your protected health information (PHI).

The Notice of Privacy Practices provides more detailed information about how West Idaho Orthopedics and Sports Medicine may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and West Idaho Orthopedics encourages reading it in full. My signature below verifies that I have received or have been offered the Notice of Privacy Practices. I understand the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone, in writing, or reviewing the Privacy Notice at www.westidahoorthopedics.com. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. West Idaho Orthopedics must receive requests for any restriction of disclosure in writing.

I hereby authorize West Idaho Orthopedics to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release West Idaho Orthopedics from any liability as a result of such transmission.

I have been informed and understand West Idaho Orthopedics will create a bill for third party payers (automobile/homeowners or other business insurances) but I am responsible to pay for all charges incurred at the time of service. All third party payers must settle privately. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services provided before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

CHECK ONE:

I authorize payment of surgical and/or medical benefits directly to West Idaho Orthopedics and Sports Medicine. I understand I am financially responsible for all charges not covered and guarantee payment of this account.

-OR-

For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment. I understand payment will be due at time of service.

No insurance coverage in force at this time

I do *not* wish to have West Idaho Orthopedics bill my insurance company for me.

Patient Name

DOB

Signature of Patient or Responsible Party/Relation

Date

Additional authorized names to receive protected health information: