ORTHOPEDIC ASSOCIATES

Authorization for Treatment

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of OASWO. I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to OASWO using and disclosing my protected health information to carry out treatment, payment, or health care operations. I understand and have been provided with the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that OASWO reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying OASWO in writing, except to the extent that OASWO has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to OASWO any information regarding my Medicare claims under title xvii and xix of the social security act.

I, _____, whose signature appears below, authorize Orthopedic Associates of SW Ohio, Inc., and its providers to view my external prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

I consent for medical photographs to be taken of me or my dependent for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in a medical textbook or journal. By consenting to medical photographs, I understand that I will not receive any payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVES

I, _____, give my written consent for Orthopedic Associates of SW Ohio to share information regarding my protected health information and care to the following listed persons; I understand that these persons may be treated as personal representatives of myself.

Personal Representatives that you may share my health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may leave a message (Check all that apply): ☐ At Home ☐ At Work ☐ Cell Phone

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I CONSENT TO UNDERSTANDING ALL OF THE ABOVE STATEMENTS

_____ _____

Patient Signature Date

Financial Responsibility Policy

This form allows OASWO to bill insurance on your behalf

It is the policy of this office that all patients, or their guarantors, are financially responsible for the services provided by Orthopedic Associates of SW Ohio, Inc.

1. We expect co-pays to be paid at the time of service.
2. The office asks that all patients assign all insurance company payments directly to the practice to avoid any misunderstandings regarding payment for professional services. The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier. If the patient is a minor or unable to sign, the responsible party/guarantor who signed the consent to treat will be responsible for any portion not covered by the insurance carrier.
3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim and/or we may not be able to bill on your behalf. If the claim is billed and denied, you will be financially responsible for services rendered.
4. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
5. Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, we will file an initial claim as a courtesy. Payment, however, is due in full at the time of service. It is your responsibility to verify this prior to your appointment.
6. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
7. We may accept assignment after verification of your coverage. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
8. All patients may be required to pay a pre-service deposit or estimated co-pays and deductibles prior to services (except in emergent situations) or amounts may be collected after services are provided, based on the current business practices of OASWO.
9. You must provide your most current billing address, all available telephone numbers and any other important contact information. If any of this changes, it is your responsibility to contact us with the updated information in a timely fashion.
10. If your insurance requires that you have a referral from your Primary Care Physician, it is your ultimate responsibility to ensure that our office receives that referral before your visit. If that is not done, you will be responsible to pay for the provided services.
11. If the doctor schedules a test for you, please check with your insurance to see if it needs precert before you have it done. Although we do our best to check, it is ultimately your responsibility.
12. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of any balance, it is your responsibility to contact our billing office within thirty days (30 days after receipt of the initial statement).
13. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney and will be assessed an additional 35% collection fee plus court costs when applicable.
14. In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $20.00 to your original balance.
15. If you are unable to keep your scheduled appointment, please notify us at least 24-hours in advance so we can accommodate our other patients. Failure to notify the office of your cancellation will result in a $50 no show fee.
16. We do charge for the completion of some business forms. Please allow 10-14 business days for processing from the date the forms are received in our office. All fees will be collected when forms are received in our office.
17. If you are a self-pay patient, please let us know and we will review our self-pay policy with you.

We accept various methods of payment including check, credit card, money order and recurring payments. If you need to set up a payment plan, please talk to our billing department. Again, thank you for your understanding and cooperation with this policy.

I do hereby understand and agree with the financial policy of Orthopedic Associates of SW Ohio, Inc. Date: _____

Signature of Responsible Party/Guarantor (if necessary): _____

Date of Birth of Responsible Party/Guarantor: _____

Relationship to Patient: _____

Prescription Refills Policy

Orthopedic Associates of SW Ohio recognizes that pain management is a vital part of the care and recovery process. It is therefore important to us that you are aware of certain policies our office has adopted regarding dispensing prescriptive pain medicine.

Following any surgical procedure and/or fractures, whether it be a result of trauma or an elective procedure, you will be discharged with care instructions and a pain prescription based on the severity of the surgery or injury you sustained.

The physician will monitor and manage your post-operative pain for a maximum period of 90 (ninety) days following the date of injury or surgery. During the time that you are under the influence of pain medication, we advise that you not drive or operate machinery.

If following the 90 (ninety) days, you still require a significant amount of prescriptive pain medication, your provider may refer you to your Primary Care Physician or our Pain Management program for evaluation and weaning of the medication.

POLICY CONCERNING PRESCRIPTION REFILLS

- The physician on call will not prescribe pain prescription refills at night or on weekends. If the pain is severe enough for you to require additional medication, we recommend you go to the nearest Emergency Department to evaluate your pain.
- Pain medication will not be prescribed at Orthopedic After Hours Clinic.

I have read the above information and understand the prescription policy of this office.

Patient's Signature:_____ Date:_____

Patient's Printed Name:_____