

Medicare Patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic Specialty Clinic, Ltd. for any services furnished to me by the providers of Orthopedic Specialty Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Date _____
Signature of Patient or Authorized Representative

Notice of Privacy Practice Acknowledgement

I understand that Orthopedic Specialty Clinic may use and disclose my protected health information for purposes of treatment, research, payment and health care operations. I also acknowledge that I received, have been offered, or have received in the past a copy of the Practice’s Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at 540-361-1830.

Date _____
Signature of Patient or Authorized Person

Authorization for Disclosure of Protected Health Information

I authorize Orthopedic Specialty Clinic to Disclose Protected health Information to the following person(s): You must specify the name of the person.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This authorization will expire the date Orthopedic Specialty Clinic receives my cancellation.

Date _____
Signature of Patient or Authorized Person