OCNE ORTHOPEDIC CENTER OF NEW ENGLAND

Patient Name_____

DOB _____

Date _____

PATIENT CONSENT & ASSIGNMENT FORM

1: CONSENT TO TREAT

I authorize OCNE and its physicians and staff to examine me and perform any tests, x-rays and other diagnostic procedures that may be helpful to care for my injury or illness.

2: PAYMENT AND FINANCIAL ARRANGEMENTS

I understand that I am responsible for paying all charges associated with my treatment. If I have health insurance, I understand that I am financially responsible if my insurance carrier denies payment and for those charges not covered by my insurance. (deductibles, co-pays and treatment not covered by my insurance plan)

I understand that if my insurance plan needs a referral or prior authorization for treatment and this has not been obtained I maybe responsible for payment of these services.

I authorize my health insurance carrier to pay OCNE directly.

If I am being treated for a work related injury, I must furnish my employer with periodic medical reports per Title 39 MSRA 52-A(2).

3: CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

We are required by federal and state law to maintain the privacy of your health information. We are required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 4-14-03 and will remain in effect until we replace it.

You may request a copy of our notice at any time.

We may use and disclose health information about your treatment, payment and healthcare operations. We maintain the right to use or disclose your health information to a physician or other healthcare professional providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of

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healthcare professionals, conducting training programs, accreditation, certification, licensing or credentialing activities.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. We may use or disclose your health information when we are required to do so by law.

You have the right to view or request copies of your health information, with limited exceptions. You must make a written request to access your health information.

Federal law makes provision for your health information to be released to an appropriate health agency, public health authority or attorney provided that a workforce member or business believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or public.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of any and all records and information, laboratory reports and x-rays to Orthopedic Center of New England, P.A. 55 Baxter Blvd, Portland, Maine 04101.

Telephone : 207-773-7428

Fax: 207-842-6229

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Signature of patient or Legal Representative Date

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Printed Name