THE CENTRAL ORTHOPEDIC GROUP, LLP DOCTOR _____ LOCATION: PLV / RVC / MASS

DATE:_____ PATIENT NAME:_____ACCOUNT #_____

CONSENT INFORMATION

CONSENT TO TREAT:

The information I have given to the Central Orthopedic Group is complete and true to the best of my knowledge. I authorize the doctors/PAs and staff of The Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary. The Central Orthopedic Group physicians/PAs and staff have implied no guarantee of cure. **Patient initials_____ Date:_____**

CONSENT TO TREAT A MINOR CHILD:

The information I have given to the Central Orthopedic Group, pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors/PAs and staff of the Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary to my child/ward in my legal custody, (if no any legal attachments) I have a signed letter giving permission to sign all documents as acting guardian. **Parent/Guardian initials _____Date:_____**

FOR WOMAN ONLY:

The doctor/PA or a staff member of the Central Orthopedic Group, LLP, has advised me that x-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patient initials_____Date:_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster and/or attorney involved in this case.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Central Orthopedic Group, LLP
651 Old Country Road
Plainview, NY 11803

Patient/Guardian Signature_____Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT:

I acknowledge that upon my request I will be provided with a copy of Central Orthopedic Group, LLP, HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information. _____

Signature:_____Name (Print):_____Date_____

HIPAA AUTHORIZATION TO RELEASE

I authorize/give permission to the following people to receive my protected health information. **List Family friends, doctors,** ETC…

_____

_____

Signature_____ Print name: _____

Signature:_____Parent/Guardian (print name)_____Date:_____

SCHOOL, SPORTS, CAMPS OR TOWN ACTIVITIES:

Patients who have been involved in a sports related accident through schools, camps, or town activities. We do not accept third party billing! You are responsible for all charges according to your own insurance policy agreement. Once all fees are paid to us by your insurance carrier and by you, we will then issue you a paid receipt for you to forward to the third-party payor involved. They will reimburse you directly.

_____
Initial here

PERSONAL INJURY PATIENTS:

You are responsible for all services directly to The Central Orthopedic Group, LLP. Once all services have been paid in full, we will then issue you a paid receipt for you to forward to your outside party involved

_____
Initial here

WORKERS' COMPENSATION INJURY:

You are responsible for providing the Central Orthopedic Group, LLP with your Workers' Compensation billing information. If this is not received at the initial visit, we will collect a $250 deposit prior to the service. This $250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified.

_____
Initial here

NO FAULT INJURIES:

You are responsible for providing the Central Orthopedic Group, LLP. Your No Fault billing information at the time of your initial visit. If this is not received at the initial visit, we will collect a $250 deposit prior to the service. This $250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified.

_____
Initial here

IN NETWORK INSURANCE:

PRIVATE INNETWORK INSURANCE WILL BE COLLECTED AT THE TIME OF YOUR INITIAL VISIT ALONG WITH A PHOTO COPY OF YOUR VALID IDENTIFICATION CARD. You will be responsible to know your insurance. If a referral is needed it is your responsibility to GET ONE or your visit will be canceled. If you have a coinsurance, deductible and or copay you are responsible to pay this at the time of your visit. KNOW YOUR INSURANCE EACH SERVICE YOU ARE RECEIVING MAY REQUIRE A SEPARATE COINSURANCE, COPAY OR DEDUCTIBLE. PLEASE DO NOT ASSUME PAYING YOUR COPAY IS YOUR ONLY RESPONSIBILITY.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND AUTHORIZE TO RELEASE: I acknowledge that upon my request I will be provided with a copy of Central Orthopedic Group, LLP, HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information. _____

_____

I _____, agree that the initialed information above it true and correct to the best of my
Print responsible party name
knowledge. I hereby permit my insurance company or the company that is processing my claims to pay The Central Orthopedic Group, LLP directly.

Patient name: _____

Patient/Guardian Signature_____Print_____Date_____

OVER ➔