CONCORD ORTHOPAEDICS

PATIENT NAME: _____DATE OF BIRTH:_____

Patient Consent:

I authorize the providers of Concord Orthopaedics to administer any treatment, perform procedures and/or radiological services as deemed necessary in the diagnosis and treatment of the patient named above.

I authorize Concord Orthopaedics employees and providers to utilize my home or work phone numbers and answering machine(s) for the purpose of disclosing appointment and/or treatment information.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I acknowledge receipt of the "Notice of Privacy Practices" and consent to the use and disclosure of medical records (including records pertaining to drug and/or alcohol use, mental health, sexually transmitted disease, HIV/AIDS testing/treatment and/or other sensitive information).

I acknowledge that Concord Orthopaedics electronic health information records will be accessible to a limited number of Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital staff to facilitate accurate and timely communication of information necessary for Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital to provide services ordered by Concord Orthopaedics providers.

I acknowledge that Concord Orthopaedics will use reasonable means to protect the security and confidentiality of e-mail communication. However, because of the inherent risks of e-mail communication, Concord Orthopaedics can not guarantee the security and confidentiality of e-mail communication and will not be held liable for improper use and/or disclosure of confidential health information that is not caused by Concord Orthopaedics' intentional misconduct.

I understand that that some insurance carriers require that I obtain an insurance referral from my primary care provider for specialty care services prior to having medical services rendered. I acknowledge that if I do not have a referral for today's visit that I will assume full financial responsibility for the services rendered if my insurance company denies my claim for these services.

I agree that Concord Orthopaedics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature:_____Date:_____
(Patient/parent/guardian signature (Must be 18 years or older)

Disclosure of Information:

If you would like us to be able to discuss your medical care and/or billing account information with anyone other than yourself, please list the name, relationship, and telephone number below.

Name	Relationship	Telephone #
Name	Relationship	Telephone #

Concord Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.