TRI STATE ORTHOPAEDICS – DR MARIE A. CZAPLICKI MARGIOTTI

HIPAA/CONSENT RELEASE

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I understand that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer and/or agents of the company and/or the listed responsible person(s), any information needed to determine these benefits or the benefit for the related services.

- I give permission for Tri-State Orthopedics to context me via text, email, phone or patient portal, in which may be artificial, prerecorded or automated messages, to take my photo for chart purposes only. I acknowledge that I have received information regarding my rights to privacy of information under HIPPA regulations

- I further acknowledge that if I want my protected health information disclosed, I must make that request to the staff and sign a disclosure release

Signature: _____ Date: _____

GUARANTEE OF PAYMENT: In consideration of services rendered to the patient names herein, I agree to be financially responsible and to pay charges for all services ordered by the physician (s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain any payment, my account to their collection agent and/or attorney. I understand that if I failed give 24 hours notice of a cancelation or a no show is recorded for an appointment a $25.00 fee will be charged.

PRE-CERTIFICATION: I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plans provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

SIGNATURE: _____ DATE: _____

CONSENT FOR TREATMENT

Upon my admission to the Tri-State Orthopedics, do voluntarily CONSENT to the rendering of such care as the physicians and personnel, in their judgment, deem necessary for my health and well-being during my admission to said department.

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (including suturing), cast application/removals and shall also include the carrying out of the orders of my treating physician and the obtainment of medication history via pharmaceutical insurance by office personnel. I acknowledge that neither the physician nor the office personnel has made any guarantee or assurance as to the results that may be obtained. Also in regards to forms, and prior authorizations we require 3 to 5 business days to complete these requests.

I HAVE READ AND UNDERSTAND THIS CONSENT.

_____ _____ _____

PATIENTS OR LEGAL GUARDIAN'S SIGNATURE DATE RELATIONSHIP

PRINT PATIENTS NAME_____ DATE OF BIRTH _____