SYRACUSE ORTHOPEDIC SPECIALISTS

PATIENT CONSENT

_____ _____
Today's Date Account # (for staff only)

_____ _____
Patient's Name/DOB Patient's Email Address

Please provide the name(s) & address(es) of any individuals with whom we may verbally share your medical information:

Name of Individual we can share information with: _____

Address: _____

Relationship/DOB: _____

Phone#: _____

Name of Individual we can share information with: _____

Address: _____

Relationship/DOB: _____

Phone#: _____

I hereby authorize Syracuse Orthopedic Specialists, PC (SOS) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for surgical/medical services to be sent directly to Syracuse Orthopedic Specialists. I hereby authorize Syracuse Orthopedic Specialists, PC to place my signature on file with Upstate Medicare Claims Division for the purpose of billing Medicare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I accept responsibility for all medical charges not covered by insurance. I agree to pay any co-pays and/or balances at the time of service unless other arrangements are made in advance. I accept financial responsibility. Correspondence regarding medical charges will be sent to the address of the insurance holder. I assume responsibility for all reasonable collection costs, including attorneys' fees. **If you feel your condition is work related, it is your responsibility to inform your employer and provider. If it is determined that your condition at the time of service is <u>not</u> work related, you will be responsible for all outstanding charges until such time as your condition is established as workers compensation**. I authorize Syracuse Orthopedic Specialists, PC to leave messages on my answering machine/voice mail pertaining to appointments or payment issues and to send correspondence to the address provided for the insurance holder unless other arrangements are made in advance. I understand that SOS will utilize text messages & emails to notify patients about future appointments and other important notifications if needed. Various SOS Providers may use a HIPAA compliant virtual medical scribing service that will assist in documenting the patient visit through secure recorded encounters. This data is encrypted in compliance with federal and state regulations. I consent to the release of any medical information about me and any other individual for whom I can give consent to my health plan and any health care providers involved in caring for me or such individual, as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations. (** *This does not replace the required HIPAA written authorization for applicants other than treatment, payment, of health care operations***) I acknowledge that I have a right to request a chaperone for today's office visit or any future visits with SOS. In the event you are having surgery at our Specialist One Day Surgery Center located in Syracuse N.Y. and they are unable to reach you by phone to perform a pre-operative interview, you allow Specialists One Day Surgery Center to discuss details of the call with those listed on this consent.

☐ I have received or was offered a copy of the SOS Patient Guide (contains valuable office procedure information)
☐ I have previously received a copy of the SOS Patient Guide. I understand I can find this guide on www.sosbones.com.
☐ I have received or was offered a copy of the Notice of Privacy Practices for Protected Health Information of SOS.

_____ _____
Patient Signature Parent/Legal Guardian Signature

_____
Printed Name of Parent/Legal Guardian