MIAMI BONE & JOINT INSTITUTE

CONSENT AND ACKNOWLEDGMENT FORM

ASSIGNMENT OF INSURANCE BENEFIT

I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for medical service render to me or my child directly to ***The Hand Institute, PL.D/B/A as Miami Hand, Bone & Joint Institute.*** These benefits are not limited to Individual Policies, Group Policies, Workers Compensation, Liability, PIP, or any other policy that may cover healthcare benefits.

Where MEDICARE / MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to ***The Hand Institute, PL.*** on my behalf.

THIRD PARTY BENEFIT COLLECTIONS

I AUTHORIZE ***The Hand Institute, PL*** to act on my behalf as attorney in fact in the collections of benefits from any responsible third party payer through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and/ or **The Hand Institute, PL** or any of its providers.

RELEASE OF INFORMATION

I authorize ***The Hand Institute, PL*** to release copies of information in their possession, as acquired in the course of me or my child's examination and/ or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments: This facility and its affiliates, utilization review agencies or auditors, Physician (Attending and consulting) and Other allied health professionals. I authorize the ordering of my prescriptions electronically with the understanding that ***The Hand Institute, PL*** will have access to my complete medication history.

RESOLVING COMPLAINTS

Patients have the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. All complaints will be handled in a professional manner by the Practice Manager, and will be investigated, acted upon, and responded to, in person, in writing or by telephone.

USE OF INFORMATION

I authorize ***The Hand Institute, PL*** and its affiliates and authorize agents to use the information acquired in the course of my child (s) or my examination and treatment to provide me with information about ***The Hand Institute, PL*** and its affiliates and other matters that may be of interest to me regarding my child's or my health care.

GUARANTEE OF PAYMENT

I hereby understand that I financially responsible for payment to ***The Hand Institute, PL*** for any charges not covered or allowable by my Insurance Company, and all deductibles, co-insurance, co-payments, and for any balance remaining after payment has been made by my Insurance Company. This includes any denials of payments due to lack of medical necessity or pre-certification / authorization, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physicians plus the cost of collection fees, and / or including reasonable attorney's fees if/ when applicable.

I further acknowledge that I have read and reviewed the FINANCIAL POLICIES of ***The Hand Institute, PL***

OPEN DOOR POLICY

Due to the nature of the practice, ***The Hand Institute, PL*** has an open door policy. Treatment areas are kept open and examining rooms are may be kept open. If you have questions or objections to this policy, please inform the physician or the designated health care provider.

NO SHOW POLICY

Any appointment not cancelled with at least 24 hours advanced notice will result in-patient or guardian incurring a non-refundable service fee of no less than $20.00.

APPOINMENT REMINDERS

I acknowledge that this practice/ facility may call for appointment reminders and/ or cancellation. I authorize the use or disclosure medical information to contact you as a reminder. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any question and/ or objections to this policy, please inform us.

PERSONAL VALUABLES

I acknowledge that this practice/ facility does not accept responsibility for any personal property. I accept the risk of loss or damages to any of my personal property.

AUTHORIZATION TO USE AND DISCLOSE PERSONAL AND MEDICATION INFORMATION FOR RESEARCH AND ACADEMIC PURPOSES

I hearby authorize the release of my personal and medical records for the purpose of research studies and academic presentations. This authorization to use and disclose personal and medical information includes:

- Demographic data such as my age (date of birth), gender, and hand dominance
- Images such as photos, videos, and x-rays
- Subjective diagnostic information such as pain score and answers to questionnaires
- Objective measures such as strength and range of motion.

I understand that this information may be used in the future for research and academic purposes. If my records are used for presentation at meetings or in publications, information that identifies me will not be used. I understand that I may be contacted occasionally to be informed of new research that I may qualify to participate in or to follow-up on my care.

RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN

I understand and acknowledge that ***The Hand Institute, PL*** and the Ambulatory Surgical Center, are owned and operated by its physicians and surgeons.

Your surgeon may have invented the implantable devices that are used in your surgery. He or His family, directly or indirectly, will receive a financial benefit when devices he invents are used. Be sure to discuss prior to your surgery any question or concerns with your surgeon.

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my health care, ***The Hand Institute, PL*** originates and maintains paper and/ or electronic records prescribing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

-A basis for planning my care and treatment,
-A means of communication among the many health professionals who contribute to my care,
-A source of information for applying my diagnosis and surgical information to my bill,
-A means by which a third-party payer can verify that services billed were actually provided &
-A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and I have been provided with a ***Notice of Privacy Practice*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

-The right to review the notice prior to signing this consent,
-The right to object to use of my health information for directory purpose, and
-The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that ***The Hand Institute, PL*** is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking

This consent, ***The Hand Institute, PL*** may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ***The Hand Institute, PL*** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ***The Hand Institute, PL*** change their notice, I have the right to obtain a copy of any revised notice. I understand that as part of this organization's treatment, payment, or health care options, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. **I acknowledge** that I have read and reviewed the **NOTICE OF PRIVACY PRACTICES** and I am in agreement of such. **I acknowledge** that I have read and understand each of the provisions appearing on this from, and that by signing this form; I consent to these provisions individually and collectively.

_____ _____

Please print Patient name OR (Parent / Guardian) Relation to patient

_____ _____

Patient OR (Parent or Guardian) signature Patient Account Number

FOR OFFICE USE ONLY

( ) Consent received by _____ on _____
( ) Consent refused by patient and treatment refused as permitted.