

Patient Consent

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations (TPO) except for any restrictions specified in the Form to Request Restrictions. Protected health information is individually identifiable information we create or receive, including demographic information relating to your physical or mental health to provision of healthcare services to you and to the collection of payment for providing healthcare services to you.

With this consent, California Pacific Orthopaedics and Sports Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, California Pacific Orthopaedics and Sports Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential. In addition, I give California Pacific Orthopaedics and Sports Medicine permission to speak with the following family members, spouse, roommate, etc. regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not sign this Consent Form, we have the right to refuse you treatment unless we are required by law to treat you. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

I have read and understand the policy as out lines above. I understand my financial responsibility as a patient.

Signature of Patient/Legal Guardian

Relationship

Patient Name (print)

Today's Date