ORTHOPEDICS OF ILLINOIS
The Bone, Joint, & Sports Medicine Center

Edward H. Kolb, M.D., *Board Certified*
American Board of Orthopedic Surgery
David L. Kieser, CNP | **Shaun M. Rudicil, PA-C**

Account Number

Consent

Consent to medical treatment: I give my consent to all care at Orthopedics of Illinois, which may include diagnostic procedures and such medical/surgical treatment as my provider(s) deem necessary or advisable, even if such care is not covered by my insurance, Medicare, Medicaid, or third party payors for any reason. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may invoke risks of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment at Orthopedics of Illinois.

Assignment of insurance benefits: I understand that I am financially responsible for any and all charges related to my care. I authorize Orthopedics of Illinois to submit claims for payment to my insurance carrier(s) or other third party payors, including Medicare and Medicaid, and to complete any forms needed to obtain payment. I assign to Orthopedics of Illinois all rights under any insurance policies, subscription certificates or health benefit indemnification agreements which provide coverage for care, including but not limited to, the right to all benefits payable for care rendered to Orthopedics of Illinois, and the right to designate a beneficiary, add dependant eligibility, and have an individual policy, certificate of agreement continued or issued. I authorize Orthopedics of Illinois to release information from my medical record to my insurance carrier(s) or government agency for the processing of claims for medical benefits.

Medicare authorization: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize payment of insurance benefits to Orthopedics of Illinois and assign all benefits to Orthopedics of Illinois to the extent necessary to cover the cost of services. I authorize the Social Security Administration to release any personal information to Orthopedics of Illinois to the extent such information in necessary to process claims for payment, including but not limited to my Medicare number, any eligibility effective dates, and birth date.

Payment for services: I understand that I am financially responsible for any and all charges not covered by my insurance, Medicare, Medicaid, or other third party payors, including deductibles, copays, and/or coinsurance amounts. I agree to pay my account regardless of such coverage. If Orthopedics of Illinois has to take additional steps to collect this account, I agree to pay all costs of collection including, but not limited to, collection fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the new collections balance due.

I guarantee payment in full of charges for care rendered at Orthopedics of Illinois. I agree to pay the account in full within 90 days from the date of the first billing, unless other arrangements are made with an authorized representative of Orthopedics of Illinois.

Notice of privacy practices acknowledgement: I have received/reviewed the Orthopedics of Illinois Privacy Statement. I am aware how medical information about me may be used and disclosed and how I can obtain access to this information.

Account Number

Patient's Printed Name

Patient's Date of Birth

Signature of Patient/Parent/Legal Guardian/Representative

Date of Signature

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HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.
2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date) _____ OR
   b. ☐ all past, present and future periods.
3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      i. ☐ Mental health records
      ii. ☐ Communicable diseases (including HIV and AIDS)
      iii. ☐ Alcohol/drug abuse treatment
      iv. ☐ Other (please specify): _____.
4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):
   a. Name: _____ Relationship: _____
   b. Name: _____ Relationship: _____
   c. Name: _____ Relationship: _____
5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.
7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Printed Name	Patient's Date of Birth
Signature of Patient/Parent/Legal Guardian/Representative	Date of Signature