PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM 1

Southwest Joint Replacement & Sports Medicine Center		
Patient Name (Last, First MI)	Date of Birth (MM/DD/YYYY)	Today's Date (MM/DD/YYYY)

Notice of Privacy Practice

_____(**Patient/Representative initials**) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_____(**Patient/Representative initials**) Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM 2

Southwest Joint Replacement & Sports Medicine Center		
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Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Refill Policy. This office requires 48-hour notice for prescription refills. All medication refills must be phoned, faxed or electronically submitted to the office Monday – Friday 8:30 AM – 4:00 PM. It is the patient's responsibility to verify with their pharmacy and our office that it has been received prior to the above deadline. There will be absolutely no refills given on the weekends.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM 3

Southwest Joint Replacement & Sports Medicine Center		
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Financial Agreement

- I acknowledge that, **Southwest Joint Replacement & Sports Medicine Center** does not treat work injuries nor accept workers compensation insurance.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, charges not covered by insurance, or charges denied for no referral.
- I understand it is my responsibility to verify that my primary care physician has authorized my visits and that my primary care physician has submitted a referral to my insurance, if required by my insurance plan. The referral must be on file in our office prior to your appointment date and time.

Form Completion

I understand there will be a $25 charge **per occurrence** for the completion of the following forms:

- Disability Forms
- FMLA
- Aflac
- Supplemental Insurance
- Medical Hardships

*Payment is due when the forms are presented and will not be completed without payment. Please allow 5 to 7 business days for completion of forms.

Appointment / Cancellation / No Show Policy

Appointments

Office visits are by appointment only. The front desk may ask about the reason for your visit. This helps us schedule the doctors time more efficiently. Please arrive 15 minutes early for your appointments. Patients who are late for any appointment may be asked to reschedule.

Same Day Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved time to another patient who is in need of being seen. *A "Same Day Cancellation" is defined as cancelling or rescheduling your appointment less than 24 hours before the schedule appointment time.*

Missed Appointments (No Show)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed care. We will not charge for a missed appointment, but we do track missed appointments. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. Once discharged from the practice we will offer 30 days of emergent care only and will transfer your medical records to your new physician. *A "Missed Appointment (No Show)" is defined as missing an appointment without cancelling at least 24 hours before the scheduled appointment time.*

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date