CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

1818 E 23rd Avenue
Hutchinson KS 67502
Telephone: (620) 259-2325
Fax: (620) 259-2337
www.capstoneortho.com

PATIENT NAME _____ **DOB**_____

RELEASE OF INFORMATION

I hereby authorize Capstone Orthopedics & Sports Medicine (Capstone Orthopedics) and its staff to release any and all information to insurance companies needed to secure payment of benefits. In addition, I authorize Capstone Orthopedics to release my protected health information to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment.

ASSIGNMENT OF BENEFITS

I authorize payment of benefits directly to Capstone Orthopedics. I understand that I am financially responsible for all charges not covered by my authorization.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The signature below acknowledges receipt of a copy of Capstone Notice of Privacy Practices (HIPAA Privacy Notice).

E-MAIL / CELL PHONE COMMUNICATIONS

By providing Capstone Orthopedics with my cell phone number and/or email address, I hereby grant to Capstone Orthopedics, and its agents or independent contractors, my consent to receive communications for treatment-related purposes (such as appointment reminders, registration instructions, surveys, etc.) and billing/payment purposes on any and all cell phone numbers I list or use (even if unlisted) or via e-mail. This includes automated, artificial voice, and prerecorded phone calls. I understand communications by text and/or e-mail are not considered secure communications and I can opt out of receiving further communications by these methods.

AUTHORIZATION FOR MEDICAL CARE

I hereby authorize Capstone Orthopedics to provide medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment

FINANCIAL POLICY

I have read, understand, and agree to the financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

REFERRAL WAIVER

I acknowledge in the course of my treatment, Capstone Orthopedics may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Capstone Orthopedics will notify me when such a referral occurs. Capstone Orthopedics assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Capstone Orthopedics make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company.

_____ _____

Signature **Date**

(Signature of patient or person legally authorized to consent/sign for patient)