HIPAA Patient Acknowledgment

I hereby permit Cleveland Orthopedic & Spine Institutes to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of Cleveland Orthopedic & Spine Institutes privacy policy. I may request a paper copy of the Cleveland Orthopedic & Spine Institutes Notice of Privacy Practices at any time. I permit Cleveland Orthopedic & Spine Institutes to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit Cleveland Orthopedic & Spine Institutes to send me any information via, electronic messaging (including email or text) or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for Cleveland Orthopedic & Spine Institutes to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission for the following individuals to receive my medical information:

______:- Patient Only

Name: ____________________ Relationship: ______________ Phone: ________________ Leave Message? YES or NO

Name: ____________________ Relationship: ______________ Phone: ________________ Leave Message? YES or NO

Name: ____________________ Relationship: ______________ Phone: ________________ Leave Message? YES or NO

Name: ____________________ Relationship: ______________ Phone: ________________ Leave Message? YES or NO

Name: ____________________ Relationship: ______________ Phone: ________________ Leave Message? YES or NO

Print Patient Name: ____________________________ Signature: ______________________________

------***--***------

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____

Signature of Patient or Legal Guardian

Patient Name:

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

CLEVELAND ORTHOPEDIC AND SPINE INSTITUTE

300 ALLEN BRADLEY DR SUITE 120MAYFIELD HEIGHTS, OH 44124-6130
(844) 746-8537

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for CLEVELAND ORTHOPEDIC AND SPINE INSTITUTE (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

Patient Name:

Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers, and/or Mental Health Providers.

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I herby provide my consent for NOMS Healthcare, LLC to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to- system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure, which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Human Resources or the IT Department.

Signature: Date:

____

--

No Show Policy

I hereby understand that Cleveland Orthopedic & Spine Institutes has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fee associated with said policy.

Signature: ______________________________

****

Payment Authorization

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM Cleveland Orthopedic & Spine Institutes DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND COINSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to Cleveland Orthopedic & Spine Institutes for services rendered. I understand this authorization will be effective until revoked in writing. I understand that, if necessary, a credit bureau report may be obtained. I understand in some cases it may be necessary to obtain insurance/employer verification. Cleveland Orthopedic & Spine Institutes cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). Cleveland Orthopedic & Spine Institutes fees are not established by insurance companies. I am responsible for my account. It is solely my responsibility to know who my insurance is in network with.

Signature: _________________________________

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, 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 health professionals who may contribute to my health 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 health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;

- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:

Patient Name: