**CONSENT FOR MEDICAL TREATMENT**
I give consent to Arrowhead Orthopaedics (AO), its staff, physicians and other practitioners to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by Arrowhead Orthopaedics for my health and well being. This also includes treatment of a minor (under the age of 18).

**MEDICAL RECORD RELEASE**
I hereby authorize any necessary medical records, prescription history, and/or diagnostic studies be released to Arrowhead Orthopaedics for management of my care.

**NOTICE OF PRIVACY PRACTICES**
I have been provided the *Notice of Privacy Practices*, which describes the use and disclosure of my protected health information that will occur during my treatment and bill payment. This *Notice of Privacy Practices* also describes my rights and the duties of Arrowhead Orthopaedics with respect to my protected health information.

**RELEASE OF INFORMATION**
I understand that Arrowhead Orthopaedics will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to Arrowhead Orthopaedics or me for all or part of Arrowhead Orthopaedics' charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of Arrowhead Orthopaedics or a third party payor; (5) for Arrowhead Orthopaedics normal health care operations. I understand that Arrowhead Orthopaedics may communicate information including protected health information with me by phone, mail, through the AO Direct Patient Portal. I understand that to ensure continuity of care, all Arrowhead Orthopaedics' providers and staff will have access to the information in my electronic health record.

**COMMUNICATION CONSENT (Check to confirm approval of method)**
I agree to allow AO to contact me using the following method(s) regarding my personal health information, evaluation and treatment. AO is authorized to leave messages for me when I am not available as indicated below:

**I HEREBY AGREE WITH AND CONSENT TO ALL OF THE ABOVE.**

# Arrowhead Orthopaedics | FINANCIAL POLICY

**Welcome to Arrowhead Orthopaedics, and thank you for choosing us as your care provider. We are committed to providing you the finest care, and like you to understand that payment of your bill is necessary for maintaining quality care. For this reason, we have adopted the following statement as our financial policy, which we require that you read, agree to and sign prior to receiving any service.**

**PAYMENT RESPONSIBILITY:** Since you are the individual seeking care, you are responsible for payment of all charges associated with your visit. As a courtesy, and for your convenience, we will bill your insurance companies when you have provided us all the requested insurance information. **You are responsible for annual deductibles, co-payments, percentages, and uncovered services at the time the service is rendered.** If uncertain of your coverage, please contact your insurance. If the insurance payment is not received within 60 days of our office billing, you are immediately responsible for the full account balance. It is the policy of Arrowhead Orthopaedics that in the case of separation or divorce, the parent bringing in a child for treatment is responsible to pay for services.

If you choose not to bill your insurance for care provided, it is understood that you assume financial responsibility for all charges. Also, if you are seeking treatment under Workman's Compensation, please submit your employer authorization for treatment. Services would be provided on a self-pay basis until the authorization is received.

**PATIENT BILLING:** Patients who have outstanding balances are billed monthly. All balances are due 30 days from the billing date. When the account balance has not been paid within 30 days of the office billing and you have not contacted the office regarding the account, your account may be referred to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to our professional collection company. Once an account has been referred to collection, the office will provide additional services to the patient or the patient's family members only if the account is paid in full, or arrangements are made for the payment of the balances due. All costs incurred in the collection process shall be added to the original balances due.

**METHODS OF PAYMENT:** We accept cash, personal checks, Visa, MasterCard, American Express and Discover as payment for our services. Payments can be made in person, by phone or through our website at http://www.arrowheadortho.com. A $45.00 fee is charged for all returned checks.

**CREDIT CARD ON FILE:** At the time of check-in, you will be asked for a credit card number to keep on file. When your insurance processes your medical claim and notifies us of your share, an AO Representative will call you to confirm the amount due and get your verbal approval for the charge. A copy of the charge (receipt) will be mailed to you or if you prefer, by e-mail.

I, the undersigned, have read, clearly understand and agree to the provisions of this financial policy. I also authorize the release of any medical information necessary to process the claim and request, from my insurance carrier, payment of benefits to Arrowhead Orthopaedics for the services rendered.

**[Please present your driver's license and insurance information to the receptionist.]**