Waiver of Responsibility and Release of Medical Information

I understand that if I am unable to obtain the proper referral/authorization from my primary care physician for my insurance, and/or in the event my worker's compensation/automobile or personal liability insurance defaults, I will be financially responsible for the services performed by Casscells Orthopaedics & Sports Medicine, in full. Our financial policy is as follows: We collect (payments & co-payments) at the time services are rendered. **PLEASE BRING ALL INSURANCE CARDS** at the time of your visit. If it is a workers compensation, motor vehicle accident or personal injury claim, please have the correct insurance information, including name, address, and claim/file numbers. **PLEASE BE ADVISED THAT IF YOUR WORKER'S COMPENSATION COMPANY IS FROM A STATE OTHER THAN DELAWRE, YOU MAY BE BILLED THE BALANCE IF NOT PAID IN FULL BY ANOTHER STATE. It is our policy THAT WE DO NOT BILL LAWYERS for office visits and/or procedures.** We require having your personal health insurance information on file, and if needed, a referral/authorization from your primary care physician for the visit. If you have any questions regarding this policy, please call our billing department at 302-832-6220.

I authorize release of all health information to Casscells Orthopaedics & Sports Medicine and from all of my previous and present treating physicians/hospitals concerning my care and treatment for the purpose of evaluation and administering my care. I also authorize Casscells Orthopaedics & Sports Medicine the ability to release my health information to requesting physicians/hospitals for the purpose of evaluation and administering my care. Also, administering claims for insurance benefits otherwise payable to my directly to Casscells Orthopaedics & Sports Medicine.

Signature of patient: _____Date: _____

Signature of parent/guardian: _____Date: _____

Insurance Authorization and Assignment

I hereby authorize Casscells Orthopaedics & Sports Medicine to furnish information to insurance carries concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance and/or if I fail to provide appropriate insurance information to process medical claims. In the event that I am in default of my account, Casscells Orthopaedics & Sports Medicine reserves the right to charge 5% of the total bill for collection agency fees. Casscells Orthopaedics & Sports Medicine reserves the right to charge for visits not cancelled within 24 hours. If patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party: _____

Relationship to Patient: _____ Date: _____

FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Casscells Orthopaedics & Sports Medicine for any services furnished to me by Casscells Orthopaedics & Sports Medicine. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services.

Signature of Patient: _____ Date: _____

PATIENT CONSENT FORM
THIS FORM IS TO BE SIGNED AND BROUGHT WITH YOU AT THE TIME OF YOUR APPOINTMENT

The Notice of Privacy Practices for Casscells Orthopaedics & Sports Medicine provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. IF we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we hall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with Health Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent allows the Practice to disclose any information to the following people

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient: _____Date: _____

Printed Name: _____