I hereby give my consent to Northeast Orthopedics, Inc., "this Practice" **to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.**

Consent for treatment: I, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to insurance carrier(s) and other payment entities for any and all payment activities. I further consent to the use for any practice operational needs.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation takes effect when the practice receives it.

SIGN: Patient/Guardian: ______________________________ Date: ______________________________

Name printed: ______________________________ If not patient, relationship: ______________________

Copy of Practice Privacy statement signed or initialed with patient/guardian on: ____________________

Patient unable to sign privacy statement due to: ____

Consent for assignment of benefits: I consent to assign payments for these services to this practice. I understand that I am responsible for co-payments, amounts applied to deductible and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of a contract, I am aware that I may be responsible for all charges that are incurred at the date of service. I understand that delinquent accounts will be sent to a collection agency.

SIGN: Patient/Guardian: ______________________________ Date: ______________________________

Revocation:

I hereby revoke the consent given above:

Sign: Patient/Guardian: ________________________________ Date: ______________________________

Name printed: ______________________________ If not patient, relationship: ______________________