

Patient Authorization Guidelines

Orthopaedic Surgery
Practice Limited to Adult
Foot and Ankle Reconstruction

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CONSENT TO TREATMENT

I hereby authorize Lone Star Orthopaedics and any of its physicians and other healthcare professionals and assistants to provide and render such medical care and treatment to the below named patient as is necessary under the circumstances, including, without limiting the generality of the foregoing, any of the following: physical examination, x-rays, medication, and office surgical procedures.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby and irrevocably transfer and assign to Lone Star Orthopaedics all insurance benefits otherwise payable to me but not to exceed Lone Star Orthopaedics regular charges for services rendered to me, and authorize my insurance carrier to pay such benefits directly to Lone Star Orthopaedics on my behalf. I understand that I may be financially responsible to Lone Star Orthopaedics for charges not paid under the assignment. I further authorize Lone Star Orthopaedics and any holder of medical information or records concerning me to release such information or records to my insurance carrier, including Worker Compensation carriers against which I have made, or shall hereafter make, a claim.

PERSONAL RESPONSIBILITY FOR PAYMENT OF SERVICES

Lone Star Orthopaedics offer, as a privilege to our patients, filing of medical claims on their behalf to their health insurance carriers. Under certain insurance plans the patient may owe office copay, which is due before services rendered. Your insurance may apply a deductible or coinsurance for services rendered in addition to your office copay. All non-covered services as determine by your insurance is the responsibly of the patient or guardian. It is your responsibility to know your insurance plan coverage. Lone Star Orthopaedics does not participate in third party billing, this also applies to motor vehicle insurance. Lone Star Orthopaedics will not accept letters of protection.

APPOINTMENT CANCELLATIONS

Cancelled appointments must be done within 24 hours of scheduled appointment . Due to the cost of lost revenue on missed appointments; we have the right to bill your account for a fee of **\$25.00**

PATIENT CONTACT INFORMATION

It maybe necessary for us to reach you by telephone with information such as test results, prescription information, physician instruction, surgery schedules, appointment information, billing information, questions. If you are not available at the phone number(s) you have provided to us, may we leave a message on an answering machine for you? Yes No, or may we leave a message with someone?

 Yes No. If " Yes" whom?: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ My initials at left acknowledge that I have received a copy of this office's Notice of Privacy Practices.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

If applicable, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize Lone Star Orthopaedics to release to the Center for Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim; I request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services of authorize such physician or organization to submit a claim to Medicare for payment to me.

I permit a copy of this document to be used in place of the original.

My signature below indicates that I have read and understand all the above information, and that I have received a copy of the Notice of Privacy Practices of Lone Star Orthopaedics, Inc

Date _____ **Signature of Patient** _____
Signature of Person Acting for Patient _____
Relationship to patient _____