HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Acknowledgment for Receipt of Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices for Houston Methodist Physician Organization and its Physicians. This Notice describes my legal rights regarding my health information and informs me of the legal duties and privacy practices of Houston Methodist Physician Organization and its Physicians with respect to health information created for services generated by Houston Methodist Physician Organization and its Physicians.

_____ _____
Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____

CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics. I understand that this consent may be revoked in writing at any time.

_____ _____
Printed Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Guarantor, if minor Date Signed

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

_____
Printed Patient Name

_____ _____
Signature of Patient or Guarantor, if minor Date Signed