Patient Acknowledgement and Consent Form

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form.

Consent for Treatment

I, _____ am requesting that health care services be provided to me (or my minor child or the patient named below) at the offices of ShoulderMD, and such other associated physicians, clinicians, and other personnel. I voluntarily consent to all medical treatment and health care-related services that are considered to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Patient: _____ Date of Birth:_____

Minor Child: _____ Date of Birth:_____

I understand that if this consent is being signed on behalf of a minor, this consent is valid until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

_____ I understand that offices of ShoulderMD may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

_____ I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to the offices of ShoulderMD, text messages and/or telephone calls or other communications. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services, and that data usage and other charges may apply.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

Medical Records Release

_____ I consent to let the offices of ShoulderMD use and disclose health information about me (or the above-named patient). In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by the offices of ShoulderMD, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent the offices of ShoulderMD or provide assistance to the offices of ShoulderMD for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above-named patient's) health care.

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_____ **Workers Comp Patients**: I hereby authorize the offices of ShoulderMD to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

Notice of Privacy Policies

_____ The offices of ShoulderMD are committed to protect the privacy of your health and personal information. This information includes both health information and individually identifiable information, such as your name, address, telephone number or social security number. The offices of ShoulderMD protect your personal and health information in electronic, written and oral forms when used throughout our office. We may modify or change our privacy practice when new laws and regulations become effective. Any changes will be effective for all personal and health information we maintain including prior information given to our office.

Financial Information

_____ **Financial Responsibility:** Subject to applicable law and the terms and conditions of any applicable contract between the offices of ShoulderMD and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay the offices of ShoulderMD for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below.

_____ **Assignment of Benefits/Third-Party Payers:** In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to the offices of ShoulderMD all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding the offices of ShoulderMD's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. I consent to any request for review or appeal by the offices of ShoulderMD to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

_____	_____
Patient or Legal Representative Signature/Date/Time	Relationship to Patient
_____	_____
Print Patient or Legal Representative Name	Witness Signature/Date/Time