Who may we discuss your medical care with?

Name: _____Relationship: _____ Telephone: _____

Name: _____Relationship: _____ Telephone: _____

May we leave voice mail messages and/or text your cell phone? ◯ Yes ◯ No Cell #_____
May we call your cell phone regarding any billing issues? ◯ Yes ◯ No

Who is your Primary Care Physician: _____

Preferred Pharmacy Name: _____Pharmacy Phone No_____

Authorization to Release Information:
I hereby authorize Woods Mill Orthopedics, Ltd to release any information acquired in the course of my examination or treatment (including any billing information) to individuals listed above. I authorize Woods Mill Orthopedic, Ltd to access my pharmacy records and/or any medical records that may be available through CommonWell Health Alliance. Woods Mill Orthopedics, Ltd participates in the Common Well Health Alliance and your general health information will be available to other participating medical providers of this program such as St. Luke's hospital.

Medicare Lifetime & Medigap Signature on File:
I request that payment of authorized Medicare, Medigap and all other insurance company benefits be made on my behalf to Woods Mill Orthopedics, Ltd, for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to my health insurance company or the Health Care Financing Administration and its agent's needed to determine these benefits or benefits payable for related services.

Telephone Calls and Automated Voice and Text Messages:
You agree that we may send you automated voice and text messages through your wireless provider to the valid mobile or landline number that you have provided us. You agree to indemnify, defend, and hold us, our technology service vender, eClinical Works, LLC, and its affiliated companies harmless from any third party claims, liability, damages or costs arising from your request to receive automated voice or text messages or from your request to receive automated voice or text messages or from providing us, your healthcare provider, with a phone number that is not your own. You agree that we and our technology solution vendors will not be liable for failed, delayed, or misdirected delivery of, any information sent to you or from you, including opt-out requests.

Advanced Beneficiary Notice of Medicare Non-Coverage and Terms of any other insurances:
I understand that when accepting any treatment or durable medical goods from my provider the charges will be billed to my insurance company or Medicare for an official decision on payment, which is sent to me on a Summary Notice. I understand that if my insurance or Medicare doesn't pay, I am responsible for payment, but I can appeal to my insurance company or Medicare by following the directions on the Summary Notice. If my insurance or Medicare does pay Woods Mill Orthopedics, Ltd will refund any payments I made to you, less co-pays or deductibles. I understand it is my responsibility to know the terms of my insurance plan. If I do not present my current insurance card or any required referral numbers or forms from my primary care physician for specialty care at the time of every visit I am choosing to go outside my plan. Additionally, there may be charges that are not covered by my insurance company. I understand I am responsible for all charges incurred by me, and I further agree to prompt payment of any services billed in these situations.

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Woods Mill Orthopedics, LTD for services provided during my care and treatment as described on the standard health care form information necessary to process claims. I authorized Woods Mill Orthopedics to appeal payments directly with my medical insurance, accept payment or dispute a payment on my behalf. I understand that I am financially responsible for the charges covered by this authorization, and I will be responsible for any collection fees or cost associated with collections. I understand I may request a copy of and/or review the Notice of Privacy Practices at any time.

I give the physicians of Woods Mill Orthopedics, LTD permission to view my prescription and health history from external sources including pharmacies, other physicians, hospitals and my health insurance.

Signature:_____Date:_____