Northern California Orthopaedic Associates Inc.

Patient Consent for use and disclosure of protected health information

With my consent, Northern California Orthopaedic Associates (NCOA) may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (HOP). Please refer to NCOA, Inc's Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. NCOA, Inc reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to: Privacy Officer, Northern Ca Orthopaedic Assoc., 2443 Fair Oaks Blvd # 394 Sacramento, CA 95825

With my consent, the office of NCOA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out HOP, such as appointment reminders, insurance items or any call pertaining to my clinical care, including laboratory results among others.

I authorize any holder of medical information about me to release information to any of the following: My insurance company, the social security administration, and/or Medicare program or its intermediaries or carriers, and/or the professional review organization. This includes information needed for processing and payment of insurance claims.

With my consent, the office of NCOA, Inc may take my/my child's photo for in-take purposes. This photo will only be used in my/my child's medical file and will not be distributed or displayed elsewhere without my prior consent. Photographs are used by medical office for familiarity and recognition of myself and/or my child by NCOA, Inc as they care for patients.

With my consent, the office of NCOA may mail to my home or other designated location any items that assist the practice in carrying out HOP, such as appointment reminders and patient statements. I have the right to request that the office of NCOArestrict how it uses or discloses my PHI to carry out HOP. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to NCOA Inc the use and disclosure of my protected health information to carry out treatment, payment and health operations. This is a life time authorization.

_____ (Patient/Guardian initials)

Financial Agreement

"I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign directly to NCOA Inc., all medical benefits, if any, otherwise payable to me for services rendered. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment for services. I authorize NCOA, Inc to perform any medical treatment as deemed medically necessary and appropriate. I authorize the use of this signature on all my insurance submissions."

Print Patient Name

Signature of Patient or Legal Guardian

Print Name of Legal Guardian (if applicable)

Date