VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

You agree, for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and /or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that our collection agency may contact me/us as described above.

Signature:_____

Date:_____

VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS

LIFETIME FORM

PATIENT'S NAME:_____

SUBSCRIBER'S NAME:_____

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Virginia Orthopaedic P.C., for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and /or their insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services.

SUBSCRIBER'S SIGNATURE:_____

DATE:_____

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO MY REFERRING PHYSICIAN.

_____

(Signature)

_____

(Date)

I AUTHORIE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO ANY PHYSICIAN OR OTHER HEALTH CARE PROVIDER TO WHOM I AM REFERRED BY MY PHYSICIAN.

_____

(Signature)

_____

(Date)

IF THERE IS ANYONE YOU WOULD LIKE US TO RELEASE MEDICAL INFORMATION TO PLEASE PRINT FIRST AND LAST NAME.

_____

(Print first and Last Name)

_____

(Signature)

VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

FINANCIAL AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned certify that the insurance information provided to Virginia Orthopaedic, PC is correct and assigned directly to Virginia Orthopaedic, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I herby authorize Virginia Orthopaedic, PC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for any and all payment not covered by insurance. I authorize Virginia Orthopaedic to submit my account for collection if not paid in full within sixty (60) days.

Responsible Party:_____

Relationship to Patient:_____

Date:_____

VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

Patient's consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Information). I herby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. Persons to whom disclosure may be made. Provider may disclose my PHI to the following persons:

   Name and telephone Number Relationship

   _____ _____

   _____ _____

   _____ _____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign consent.

6. Redisclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

_____ _____
Patient or Representative Signature Date

Representatives Authority: _____
(Parent, Custodial Parent, Legal Guardian, POA)

VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS

LIFETIME FORM

PATIENT'S NAME:_____

SUBSCRIBER'S NAME:_____

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Virginia Orthopaedic P.C., for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and /or their insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services.

SUBSCRIBER'S SIGNATURE:_____

DATE:_____

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO MY REFERRING PHYSICIAN.

_____

(Signature)

_____

(Date)

I AUTHORIE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO ANY PHYSICIAN OR OTHER HEALTH CARE PROVIDER TO WHOM I AM REFERRED BY MY PHYSICIAN.

_____

(Signature)

_____

(Date)

IF THERE IS ANYONE YOU WOULD LIKE US TO RELEASE MEDICAL INFORMATION TO PLEASE PRINT FIRST AND LAST NAME.

_____

(Print first and Last Name)

_____

(Signature)