Litchfield Hills
Orthopedic Associates, LLP

SPECIALIZED CARE YOU CAN TRUST

www.LHOA.com

CONSENT TO TREATMENT AND USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO TREATMENT:

I consent to clinical care and treatment by Litchfield Hills Orthopedic Associates. I consent to any routine diagnostic procedures and any other service provided to me by or at the direction of my provider.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI):

I consent to LHOA's use of my PHI, including drug and/or alcohol abuse information, psychiatric information, and HIV-related information, for treatment, payment, and healthcare operations. LHOA may disclose or allow electronic access to my PHI so that my primary care provider, referring physician(s), and other healthcare providers have this information when treating me and coordinating my healthcare. I also allow LHOA to disclose my PHI to the health insurance plan or payer financially responsible for my care. To avoid disclosure to my health insurance plan, I must agree in writing that I will self-pay for my care. If I have agreed to self-pay for care at LHOA, I may receive a copy of those charges by contacting the billing department.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Before signing this consent, I had opportunity to receive and/or review LHOA's Notice of Privacy Practices (NoPP), and consent to the use and disclosure of my PHI for treatment, payment, and healthcare operations. I may receive notification of any future changes to these privacy practices by contacting LHOA's Privacy Officer. While I may request restrictions to how LHOA uses and/or discloses PHI about me for treatment, payment, or healthcare operations, LHOA is not required to agree to my restrictions and in these circumstances may refuse to provide non-emergency care.

FOR STAFF USE ONLY:

If unable to obtain patient's consent or provide Notice of Privacy Practices, indicate the reason:

❒ Emergency ❒ Patient refusal ❒ Other: ____

ASSIGNMENT AND AUTHORIZATION MEDICARE/MEDICAID/COMMERCIAL INSURANCE CERTIFICATION:

I certify that the insurance information given by me to pay my bills is correct. I authorize LHOA to release to my insurance company any information needed for payment and request that payment of authorized benefits be made on my behalf. I assign the benefits payable for LHOA providers furnishing services to me and authorize LHOA to submit claims to potential third-party payers for me. I request that this consent form apply to all services related to my care. This consent will be valid for one year. I have the right to revoke this consent by contacting LHOA's Information Management Department, except when they have already taken steps relying on this consent.

______________________________________	______________________
Patient Signature or Authorized Representative	Date
______________________________________	______________________
Print Name	Date of Birth

Litchfield Hills Orthopedic Associates, LLP, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.