

Name:
DOB:
Chart:
Age/Sex:
Date: 5/13/2017



PERMISSION TO RELEASE INFORMATION & ASSIGNMENT

I have read and agree to the following:

1. Provide a current, personal and private email address that only you have access to. By providing an email address, you agree to have Advanced Joint Replacement Center provide you with secure access to your health information.

Email address: _____ (Not Required)

1. Assign to the Physicians at Advanced Joint Replacement Center all payments to which I am entitled for medical and surgical expense related to the service performed by them, and direct that checks for such services be made payable to them. _____ Initial
2. Authorize the above physicians to release such information as may be required by my attorney and/or my insurance company and/or referring doctor. _____ Initial
3. I understand that I am responsible for the payment of the bill, regardless of whether the charges may be covered by insurance in or out-of-network, or also be the responsibility of some other party. This includes supplies that I may receive that are not covered by Medicare or other plans. _____ Initial
4. If the problem for which you are seeing one of our doctors involves litigation, as may result from an automobile accident or liability, be advised that we do not wait for payment until the litigation is settled. We will accept monthly payments on your account excluding worker's compensation. _____ Initial
5. EPrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. I hereby provide informed consent to Advanced Joint Replacement Center to enroll me in the ePrescribe Program, if I am not already enrolled. _____ Initial
6. I agree that Advanced Joint Replacement Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. _____ Initial
7. I authorize Advanced Joint Replacement Center and its staff, to leave detailed messages at the primary phone number provided _____ Initial
8. A 24 hour notice is required for any cancellations or reschedules. If you no-show for your appointment 2 times, you may not be able to reschedule. If you're more than 10 minutes late to your appointment it will be cancelled. _____ Initial
9. **If you are unable to pay your balance due to a large amount, we may set you up on a payment plan to be satisfied within a maximum of 90 days. If you default on you payment plan the agreement will be void and the account will automatically be turned over to a collection agency without further notification to you. Once set up on a payment plan any additional office visits must be paid in full at the time of service or appointment will be cancelled.** _____ Initial
11. I understand that my information will be shared with AJRC's third party billing service(s) providers:
Physource Billing Solutions and Specialty Care Practice Management (SCPM) _____ Initial

Signature of patient or legal guardian: _____

Date: _____

Please turn over...->