WASHINGTON ORTHOPAEDIC CENTER

CONSENT TO TREATMENT
MEDICARE AND INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medigap and insurance benefits be made on my behalf to Washington Orthopaedic Center for any services given to me by the physician/provider/supplier. I authorize any holder of my personal medical information to release that information as needed to my current insurance plan.

I authorize medical care for _____ and in doing so, I hereby authorize my insurance benefits to be paid directly to the physician. I understand that I remain financially responsible for payment for all services according to WOC policy, regardless of any pending insurance claims. I authorize the physician and WOC to release my medical information to my current insurance company(ies) for the processing of claims and for the appeals of any claims on my behalf.

In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be in Lewis County.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness, you are specifically authorized to release to the insurance company listed on the other side of the form or entity all information or medical records relating to the diagnosis, testing or treatment*. *If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating sexually transmitted disease

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information necessary for this or a related Medicare claim/other insurance claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulation pertaining to Medicare assignment of benefits applies. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

E-PRESCRIBING PBM CONSENT

By signing this consent form I agree that Washington Orthopaedic Center can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We at Washington Orthopaedic Center keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so* or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Medical Records Supervisor at 360-330-1873.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

UNDERSTANDING OF PRIVATE BILLING

I understand that my provider may bill me directly for today's charges if:

- Today's visit for medical treatment is not covered by my **managed care plan** and I still wish to be seen regardless of my coverage.
- Washington Orthopaedic Center is **not** contracted with my insurance plan and I wish to be seen regardless. (WOC will not bill any insurance company they are not contracted with. If I am granted retro coverage through a Medicaid plan and do not have an authorization/referral in place or if charges are non-covered, I will be financially responsible for those charges.
- Washington Orthopaedic Center **is** contracted with your insurance plan, but you wish to pay out of pocket. You wish to be billed directly, without submitting claims to your insurance plan.
- My Primary Care Physician has **not referred** me to this office, but I wish to be seen regardless of my coverage.
- I have **medical insurance**, but I do not have my medical ID card with me.
- **I have a Labor & Industry/Workers Comp, Motor Vehicle, Crime Victim, or other Personal Injury** claim that is not yet approved, is in appeal status, or has been denied/rejected.

RELEASE OF INFORMATION DELEGATE

*Washington Orthopaedic Center may disclose verbal and written information regarding my condition / treatment to the following individuals listed below. I understand I may revoke this request in writing at any time.

Person(s) to release information to	Date of Birth	Relationship	Phone number
Person(s) to release information to	Date of Birth	Relationship	Phone number

By my signature below, I acknowledge and agree to all the above information.

Printed Patient Name

Date of Birth

Patient or Guardian Signature

Date

Printed Name if not the patient

Relationship (Parent, legal guardian, or personal representative)

Updated 2/4/2021

Washington Orthopaedic Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.