



NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for **The Methodist Hospital Physician Organization** and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of **The Methodist Hospital Physician Organization** and its Physicians with respect to health information created for services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices, please do not hesitate to call **The Methodist Hospital Physician Organization's** Business Practices Officer at 713.383.5125.



Patient Name: _____

Signature of Patient or
Patient's Qualified Personal Representative: _____

Date: _____

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained: _____

Processed by: _____



CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics. I understand that this consent may be revoked in writing at any time.

PATIENT NAME (PRINT NAME)

PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT or GUARANTOR, if minor

DATE SIGNED

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

PATIENT NAME (PRINT NAME)

SIGNATURE OF PATIENT or GUARANTOR, if minor

DATE SIGNED



PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

I GIVE PERMISSION for Dr. David Lintner to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: Relationship: Name: Relationship: Name: Relationship: Name: Relationship:

I DO NOT GIVE PERMISSION for Dr. David Lintner to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

I GIVE PERMISSION for any surgery centers or hospitals associated with Dr. David Lintner's practice to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: Relationship: Name: Relationship: Name: Relationship: Name: Relationship:

I DO NOT GIVE PERMISSION for any surgery centers or hospitals associated with Dr. David Lintner's practice to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

* Patient's Signature: Date:

Patient's Printed Name:

Signature of Witness: Date:

* Patient is a minor (___ years of age) *OR is unable to give permission because:

Signature of Individual Signing on Behalf of Patient: Date:

Legal authority to act on the patient's behalf: