St. Cloud Orthopedic Associates, Ltd.
1555 Northway Drive, St. Cloud, MN 56303 (320) 259-4100

Patient's Name: _____ **Date-of-Birth:** _____ **Chart ID:** _____

I. Consent and Authorization for Release of Information

1. Release of Information. I consent to the release and use by St. Cloud Orthopedic Associates, Ltd. (referred to as "SCOA") of medical and other information about me to the extent permitted by law to the following:

   - To a health care provider being advised or consulted in connection with my treatment or care;
   - To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
   - To a person or organization in connection with SCOA's health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.
   - To the following individuals (name spouse or family member, coach, trainer, employer or others): _____

2. Revocation. I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to SCOA.

II. Payment Authorization

1. Payment Responsibility. I agree to pay for all services furnished to me by SCOA, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by SCOA's contract with my health plan or applicable law. I further agree that an interest charge of 1% per month (equaling an annual rate of 12%) will be applied to my account balance if I do not pay charges within 90 days of the posting date. I also agree to pay or reimburse SCOA for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. I have received a copy of SCOA's Credit Policy and agree to its terms.

2. Payment Authorization. I authorize SCOA to directly bill my health plan or third-party payor for services rendered to me by or on behalf of SCOA, but acknowledge that SCOA is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to SCOA for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to SCOA directly on my behalf by my Medigap insurer. I understand and agree that SCOA is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

3. Statement to Permit Payment for Medicare Benefits to SCOA. If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to SCOA, for any services furnished to me by or in SCOA, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

III. Notice of Privacy Practices

1. Confidentiality. It is the policy of SCOA to protect the privacy and confidentiality of patients' medical information.

2. Notice of Privacy Practice. SCOA's Notice of Privacy Practices explains how SCOA may use and disclose my medical information. It also explains my rights regarding this kind of information. SCOA may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. SCOA's Notice of Privacy Practices is available at the Reception Desk.

3. Acknowledgment of Receipt. I acknowledge that I have received SCOA's Notice of Privacy Practices.

Signature of Patient (if applicable): _____ Date: _____

Signature of Legal Guardian (if applicable): _____ Date: _____