

PATIENT CONSENT FORM CORE@MOSM

1. I, the undersigned, do hereby agree and give my consent for the Center of Rehabilitative Excellence at Metrocrest Orthopaedics and Sports Medicine to provide me with medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition.
2. I understand that there is a copy of the Notice of Privacy Practices, available for me to read. The HIPAA Privacy Notice describes the Practice's obligation to ensure the privacy of my health information. This HIPAA Privacy Policy Notice also describes how the practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask for clarification of it. I understand that the Practice is required to maintain privacy of my health information in accordance with the terms of the HIPAA Privacy Notice. A copy of the Practice's HIPAA policy is available upon request, and a copy of the policy is posted in the lobby.
3. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have any effect on any actions the Practice has already taken in reliance on this consent.
4. I hereby assign all medical, physical therapy, occupational therapy, and rehabilitation benefits to which I am entitled, including Medicare, private insurance, and third party payers to CORE and Metrocrest Orthopaedics and Sports Medicine.
5. I authorize the facility to obtain copies of necessary records from any hospital, doctor, or other medical provider who has treated or examined me for any condition that pertains to and improves the facility's ability to provide quality patient care for the rehabilitation services for which I have been referred.
6. I am aware of the Cancellation and No Show Policy- I understand that cancellations should be requested 24 hours prior to the appointment, unless extenuating circumstances prevent otherwise. A \$25.00 fee may be enforced for no shows or late cancellations.

Signature of patient or authorized representative

Date