



I hereby acknowledge receipt of the practice's *Notice of Privacy Practices*. *The Notice of Privacy Practices* provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be posted in the practice's offices and will be provided to me upon request. I understand this consent is valid until revoked by me in writing.

Name of Patient's Spouse:	<input type="checkbox"/> OK to discuss information or leave message with spouse
Patient's Emergency Contact Person:	<input type="checkbox"/> OK to discuss information or leave message with this person
Emergency Contact's Daytime Phone Number: (       )	

**Financial Responsibility**

I have received a copy of SportsMed Wheaton Orthopaedics' Financial Policy dated 02/09/07. By signing below, I am agreeing to the terms of the Financial Policy. I understand and agree that it is my responsibility to notify SportsMed Wheaton Orthopaedics of any changes in my health care coverage. I understand and agree that it is my responsibility to contact my insurance company with any questions I have including those about potential benefits and SportsMed Wheaton Orthopaedics' participation with my particular insurance plan. I understand and agree that it is my responsibility to obtain referrals from my PCP if they are required by my plan. I understand and agree that, if I fail to comply with the statements above or the terms of the Financial Policy, any amount unpaid by my insurance plan will be my financial responsibility. I agree to pay for any unpaid balance that is my financial responsibility.

**Assignment of Benefits and Authorization to Release Information**

I authorize direct remittance of payment for all insurance benefits, including Medicare, if I am a Medicare beneficiary, to SportsMed Wheaton Orthopaedics for all covered services and supplies provided to me during all courses of treatment and care. I authorize the release of any medical or any other information to my insurance carrier(s) or any other entity necessary to determine insurance benefits for related medical services and/or supplies, determine treatment, and other health care operations provided to me by SportsMed Wheaton Orthopaedics. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

**By signing below, I attest that the information listed above is accurate to the best of my knowledge.**

**X** \_\_\_\_\_ \_\_\_\_\_  
**Signature of Patient** **Date**  
**or Parent or Legal Guardian if Patient is a Minor (younger than 18 years old)**

<b>If Patient is a <span style="color: blue;">Minor (younger than 18 years old)</span></b>	
Complete the following section listing <u>any</u> and <u>all</u> parties that you are giving permission for SportsMed Wheaton Orthopaedics to discuss information or leave messages with regarding the patient:	
Mother's Name:	Father's Name:
Mother's Telephone Number: Home Work Cell (       )	Father's Telephone Number: Home Work Cell (       )
Step-Mother's Name:	Step-Father's Name:
Step-Mother's Telephone Number: Home Work Cell (       )	Step-Father's Telephone Number: Home Work Cell (       )
Other's Name:	Other's Name:
Relationship to Patient:	Relationship to Patient:
Other's Telephone Number: Home Work Cell (       )	Other's Telephone Number: Home Work Cell (       )