

Name:
Chart:
Date:
DOB:



Princeton Orthopaedic Associates II, PA
325 Princeton Avenue
Princeton, New Jersey 08540
(609) 924-8131

Patient Acknowledgment & Consent

Acknowledgment of Privacy Practices

I have received or have been given the opportunity to receive this practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

Release of Information

I hereby consent to the release of information provided to, or generated by Princeton Orthopaedic Associates, to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment of Benefits

I hereby assign medical benefits otherwise payable to me to Princeton Orthopaedic Associates II. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances. I authorize Princeton Orthopaedic Associates II, PA to file claims on my behalf for services rendered to me. I understand that payment in full is due at the time services are rendered.

Communications

I hereby expressly agrees and consents to Princeton Orthopaedic Associates II PA, their employees, agents, collections agents, service providers and the like ("Provider(s)") to contact me using any contact information that I or my representative provides to any Provider(s), including mail, email, phone call or text message (further including contacts via wireless telephone numbers or other numbers which may result in charges to me). I expressly consent to Provider(s) contacting me on this telephone number regarding my hospitalization, my appointments, medical services rendered or to be provided, my financial obligations, financial assistance for my account(s), or any matter relating to my medical care. I understand that methods of contact may include pre-recorded or artificial voice messages and/or automatic telephone dialing or texting systems.

Consent to Treatment

I hereby consent to examination and treatment by Princeton Orthopaedic Associates II. I agree that Princeton Orthopaedic Associates II may request and use my prescription medication history from other healthcare providers or third party benefit payers for treatment purposes.

Medicare Assignment

Medicare Release

Under the Medicare Law, Effective 9/1/1990, it is our obligation to process Medicare claims for our patients. In order to comply with this law, it is necessary that we have you sign the following statement:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Princeton Orthopaedic Associates for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient's Name _____

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient): _____