Downtown Office
350 Lafayette Ave SE
Grand Rapids, MI 49503

Southwest Office
2373 64th St. SW
Byron Center, MI 49315

Phone: (616) 456-8515
Fax: (616) 456.8208
www.rvorthopedics.com

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA requirements, River Valley Orthopedics, PC has posted the Notice of Privacy Practices in a clear and prominent location where I was able to view. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of the entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.

In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization or provide valid, active insurance at the time of the visit.

Please be advised that all co-pays, deductible and non-covered services are due at the time of the visit.

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits.

Patient Acknowledgment

I acknowledge that I understand River Valley Orthopedics Notice of Privacy Practices and have provided valid and active insurance information (if available), otherwise I will be deemed responsible for the payment of the services received.

_____ _____

Patient Signature Date

_____

Patient Name (Please Print)

_____

Parent/Guardian/POA Signature

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Patient Consent & Authorization

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Communication with laboratories or other specialists for any medical treatment, consultations, and educational purposes or for any other purpose deemed appropriate by River Valley Orthopedics, PC.

_____ _____
Patient Signature Date

_____
Patient Name (Please Print)

_____
Patient or Parent/Guardian Signature

Please list any individuals we are allowed to share all your protected health information with:

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

For Office Use Only

Patient Refused to Sign

The following circumstances prohibited the patient form signing the Acknowledgement.

_____
_____
_____
_____

_____
Office Personnel Signature

_____
Office Personnel Name (Please Print)

_____
Date