PINEHURST HIP & KNEE CENTER, P.A.
JASON E. GUEVARA, M.D.
PO BOX 759
Pinehurst, North Carolina 28370

This acknowledgment of Notice and Consent authorizes **PINEHURST HIP & KNEE CENTER, P.A.** to use and disclose health information about you for treatment, payment and other healthcare related purposes.

Payment for Services: As a courtesy to our patients, we will promptly file your insurance claims, however, we ask that you be prepared to pay any required co-payments, deductibles or services not covered by your insurance plan at the time of your visit.

Fracture Care and Surgery: We will file your insurance for fracture care and surgical charges within a week of the service. However, if our office does not hear from your insurance company within 30 days, we kindly ask that you contact your insurance company to address the delay in payment.

Authorization of Payment: I hereby authorize that payment may be made to my physician for Medicare or other insurance benefits for services rendered. I understand that I am financially responsible for any charges not covered by my insurance and I agree to pay for such services.

Authorization for Release of Information: I hereby authorize the designated physician to furnish or obtain any medical information requested by any physician assisting with my care, by insurance companies with whom I have coverage, or any agency which may be assisting in my medical care or in payment for my medical care. Pinehurst Hip & Knee Center, P.A. is committed to respecting the confidentiality of your protected health information (PHI) that is in our possession and only using and disclosing your (PHI) as necessary in providing you with orthopedic treatment and services.

Authorization for Treatment: I hereby authorize examinations, x-rays, treatments, medications, and minor surgical procedures as may by prescribed by the physician in charge of my care.

Notice of Fees: Pinehurst Hip & Knee Center, P.A. reserves the right to charge the patient a $50 specialist fee for any **confirmed** appointments that are missed. When Medical Records are requested by the patient, a $10 fee will be charged to the patient and payable at the time of pickup. There is also a $10 fee for completion of FMLA, Short Term Disability and any other miscellaneous forms, (each time) and charged to the patient and payable at the time of pickup.

Notice of Appointment Policy: For courtesy, we provide reminder calls for upcoming appointments. We kindly ask that you return our call and confirm your appointment greater than 24 hours prior. If we have not received a confirmation, we will fill your appointment time with someone else on our wait list and will be glad to reschedule your appointment for a later date.

Notice of Privacy Practices: The Pinehurst Hip & Knee Center, P.A. has a Notice of Privacy Practices and is required by the Health Insurance Portability and Accountability Act (HIPAA) to inform our patients of their rights and duties regarding the privacy of their health information. It describes how we may disclose and use your protected health information (PHI) and how you can access and exercise other rights concerning your PHI.

Right to Make Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the to the date of the effective date of change.

Please review our current brochure for more information regarding the Acknowledgment and Consent Notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Pinehurst Hip & Knee Center, P.A. regarding the use and disclosure of my Protected Health Information.

I Authorize Pinehurst Hip & Knee Center, P.A. to release medical information, which relates to my care to the following individuals:

1._____ _____ _____
Name **Relationship** **Telephone Number**

2._____ _____ _____
Name **Relationship** **Telephone Number**

_____ _____
Patient's Signature **Date**

_____ _____ _____
Parent's Signature (if child is minor) **Printed Name** **Date**

Patient Name: _____ **DOB:** _____

THIS CONSENT IS VALID X 12 FULL MONTHS FROM THE DATE SIGNED