BEND SPINE AND NEUROSURGERY

2421 Northeast Doctors Drive Bend, OR 97701 P: 541-647-1638

ACKNOWLEDGMENT AND CONSENT

I understand that **Bend Spine and Neurosurgery** will use and disclose **health information** about

_____

(Patient Name)

I understand that his/her **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about his/her health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that This Practice may **use and disclose** his/her health information in order to: *make decisions about and plan for his/her care and treatment; *refer to, consult with, coordinate among, and manage along with other health care providers for his/her care and treatment; *determine his/her eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of his/her health care; and *perform various office, administrative and business functions that support his/her physician's efforts to provide him/her with, arrange and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about him/her. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of this practice, and his/her rights regarding his/her health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of the Notice of Privacy Practices in effect will be posted in waiting/reception area. I understand that I have the right to ask that some or all of his/her health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Signature:_____Date:_____

(Patient or Patient Representative)

List the names of anyone that you would like our office to disclose personal medical information to.

_____

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FINANCIAL AGREEMENT

I acknowledge that I will be financially responsible for all charges, whether or not paid by my insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. **There will be a $25.00 service charge on all returned checks.** In addition, I authorize Bend Spine and Neurosurgery to release information, as necessary, in order to facilitate treatment, payment or other healthcare operations.

Publication of Records: I authorize photos, slides, or any other viewing of my care and treatment during or after its completion to be used for the advancement of medicine and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

MEDICATION HISTORY AUTHORIZATION

I give Bend Spine and Neurosurgery authority to import my medication history from insurance/pharmacy database.

SIGNATURE:_____ **DATE**_____