BROC
BATON ROUGE ORTHOPAEDIC CLINIC

GENERAL CONSENT FOR TREATMENT

I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), healthcare student(s), and clinical staff to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science and acknowledge that no guarantees have been made to the patient named on this form.

Medical Education*

I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows, and other providers and observers, who are supervised by qualified faculty in accordance with organizational policies

Photography and Other Recordings*

I consent to photographs, audio and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case studies and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in the exam room.

Authorization for Healthcare-Related Calls, Texts and E-mails

I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and also to emails using any email address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

Baton Rouge Orthopaedic Clinic
Attn: Medical Records
8080 Bluebonnet Blvd., Ste. 1000
Baton Rouge, LA 70810

If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R.S. 40:1299.53. Such third party's consent and authorization, however, is only valid for the period of my incapacitation.

Specimens

Further, I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic, or educational purposes, or disposal at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention or medical treatment.

Devices

I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

Blood

Further, I understand that should any medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires the hospital and/or physician to report certain infectious diseases including sexually transmitted diseases to the state's Department of Health.

PATIENT RESPONSIBILITIES

Payment Guarantee & Insurance Authorization/Assignment of Insurance Benefits

I agree to pay for all past due balances that were unpaid by my insurance company, copays, co-insurance, deductibles, or non-covered charges for diagnostic procedures and medical treatment, and I understand that payment is due at the time of service. If I do not have medical insurance, I understand that it is my responsibility to make financial arrangements prior to services rendered. I further authorize third parties to pay directly to Baton Rouge Orthopaedic Clinic (BROC) for any insurance benefits due for services rendered on behalf of me or the named patient. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Baton Rouge Orthopaedic Clinic (BROC). I agree to notify Baton Rouge Orthopaedic Clinic (BROC) of any changes in insurance, address, or other information included in patient registration I understand I am responsible for all charges not paid by my insurance company. If it becomes necessary to collect any sum due through an attorney, then, I agree to pay reasonable costs of collection including attorney's fees, whether a suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts.

I understand that I am responsible for verifying that my provider participates with my insurance plan and that I must present a copy of my card at each visit.

I understand that if the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. Baton Rouge Orthopaedic Clinic (BROC) does not become involved in third-party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee.

I understand that any account that has been placed in delinquent status will be sent to an independent collection service. This balance may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship. If you are having financial difficulties that prevent you from paying your balance, please ask your patient service representative for a Financial Assistance application.

Authorized Representative

By signing this document, I give written consent to Baton Rouge Orthopaedic Clinic (BROC) to act as my authorized representative in any internal or external review of an adverse claim determination under Louisiana Administrative Code Title 37 Chapter 62, Medical Necessity Review Organizations, or other state or federal administrative regulation governing medical necessity review, or subsequent appeal of such determination. I understand that in the event that the service is determined not to be medically necessary, and I thereafter request the services, nothing shall prohibit the provider from charging usual and customary charges for all non-medically necessary services provided.

Pre-Certification

Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. However, it is your responsibility to confirm that you have been granted approval or certification before your appointment or you will be responsible for any charges insurance has not granted prior approval.

Termination of Physician-Patient Relationship Policy

Your physician at his/her discretion and judgment, may discontinue treatment of a patient for rude, inappropriate, or egregious behavior, noncompliance with treatment recommendations, failure to obtain medically necessary referrals or further testing, failure to follow medication regimens, failure to meet financial obligations, or breakdown of the physician/patient relationship.

Other Physician Charges

Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as pathology, laboratory, and/or radiology interpretation services.

Forms, Letters, and Copies of Medical Records

These fees will not be filed with your insurance. You will be personally charged. This includes the completion of all forms, letters, and copying of medical records. Copies of medical records will be charged to the requesting party by the copying company.

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Acknowledgement of receipt and signature via MYCHART, Electronically or Hard Copy:
(Please initial each)

By initialing each item below and providing my signature and date at the bottom of this form, I acknowledge and agree to the following:

Consent to Treatment

_____ I consent to and authorize treatment by Baton Rouge Orthopaedic Clinic.

HIPAA Acknowledgement

_____ I acknowledge that I have received a copy of the 'Notice of Privacy Practices'.

Authorization and Assignment

_____ I authorize Baton Rouge Orthopaedic Clinic to release medical information as needed to submit and process insurance claims for reimbursement. I also assign claim payments, including major medical benefits, to be made directly to Baton Rouge Orthopaedic Clinic. I understand that any overpayment will be refunded to me upon request, regardless of insurance. This authorization and assignment may be revoked by providing written notice at any time.

Financial Responsibility

_____ I acknowledge that I am responsible for paying co-payments and deductibles at the time of service, as well as any amounts not covered by insurance.

Notifications

_____ I consent to receive automated calls, text messages, and email notifications at the contact number and email address I have provided for appointment reminders and other notifications.

By signing below, I acknowledge that I have read this form and fully understand and accept its terms and conditions, and I have had the opportunity to ask any questions. If the patient is not a minor but is unable to consent, the authorized person should sign below. If the patient is a minor or otherwise unable to provide consent, the initials above must be observed by witnesses, who must also sign below.

Name_____ *(Please print legal name)*

Signature_____ Date_____