Signature on File

_____ _____

Patient's Name Date

Medical Information can be discussed with:

Patient Only_____ Family member or friend: _____
Relationship: _____ Phone: _____

Can detailed messages regarding medical results be left on answering machine/voicemail? __Yes __No
Telephone Number:_____ Circle one: Home Work Cell Other_____

Financial Information can be released to:

Patient Only _____ Family member or friend: _____
Relationship: _____ Phone: _____

_____ _____ _____

Signature of patient or responsible party Name & Relationship (Other than patient) Date

****

- I authorize use of this form for all my insurance submission.
- I authorize release of information necessary to process claims to all my insurance companies.
- I authorize my doctor to act as my agent in helping me to obtain payment from my insurance co.
- I authorize payment directly to my doctor.
- I permit a copy of the authorization to be used in place of the original.
- I am responsible for understanding my insurance coverage.
- I understand that I am responsible for my bill.
- I authorize San Mateo Orthopedic Medical Group to furnish information concerning my present Illness.

_____ _____ _____

Signature of patient or responsible party Name & Relationship (Other than patient) Date

****

I acknowledge having been offered or having received a copy of San Mateo Orthopedic Medical Group's "Notice of Privacy Practices."

_____ _____ _____

Signature of patient or responsible party Name & Relationship (Other than patient) Date

This consent forms is good for 6 years and must be updated if patient is not seen in a 2 year period

77 North San Mateo Drive San Mateo, CA 94401 Tel: 650-342-0849 Fax: 650-347-8612
www.sanmateoorthomed.com