2800 Tamarack Ave, Suite 104, South Windsor, CT. 06074

HIPAA Privacy Practices

With my consent, EOSM (the practice) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. EOSM reserves the right to revise its Notice of Privacy Practices at anytime. A revised notice of Privacy Practices may be obtained by verbal request to the Privacy Office at 2800 Tamarack Avenue, South Windsor, CT. 06074.

With my consent EOSM may call my home or other designated location and leave a message on voice mail or to person in reference to any items and any call pertaining to my clinical care, including laboratory results among others, and insurance information.

With my consent, EOSM may mail to my home or other designated location items that assist the Practice in carrying out TPO, such as appointment reminder and patient statements as long as they are sealed.

With my consent EOSM may call my home for appointment reminders and abnormal test results. I have the right to request that EOSM restrict how it uses or discloses my protected Health Information or carry out treatment, payment and healthcare operations. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to EOSM use and disclosure of my protected Health Information. I may revoke my consent in writing accept to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, EOSM may decline to provide treatment to me.

For third party payers: I hereby authorize the release of any information related to my medical care, as required by government agencies and insurance carriers. I assign benefits to EOSM and understand that in the absence of accepted insurance carriers. I assign benefits to EOSM and understand that in the absence of accepted insurance coverage, I am responsible for full payment of services rendered.

_____ _____

Signature of Patient of Legal Guardian **Date**

PAYMENT POLICY

If you do not have insurance, payment will be expected on the day service is provided. An initial payment of $100.00 will be required for your first visit. $50.00 will be required for each follow up. There maybe add on services such as a brace, splint which would be an additional cost.

All co-payments must be paid when checking in with the receptionist.

As a courtesy to our patients, we will file an insurance claim for service, provided that you have signed the authorization section on our Patient Information Sheet.

If your insurance requires a referral, you will be responsible for obtaining the referral to see our orthopaedic specialist. If referral is not received you will be responsible for full payment for the visit or your visit will be rescheduled.

You are responsible to pay any balances due EOSM within 30 days after your insurance pays their portion. If payment is not received EOSM will send one reminder letter. If you do not pay after receiving our Past Due letter your account will receive a Final Notice letter and your account will be turned over to a Collection Agency within 10 days to be processed for non payment.

All checks returned for NON-SUFFICIENT FUNDS will be subjected to a $30.00 additional charge.

If you are unable to keep your scheduled appointment, you must notify our office 24 hours prior to your visit. If you do not call the office you will be charged a $30.00 fee for no show.

I have read and understand the above payment policy.

Responsible Party _____ **Date**_____