Consent to Treat and Financial Responsibility

Account Number: _____

Consent to Treat

I hereby authorize employees and agents of the Orthopedic Institute of North Texas (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to the Orthopedic Institute of North Texas, PLLC (hereinafter "OINT") and/or its affiliates or designees and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to OINT. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of OINT, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent for Photography/Videography

The Department of Health and Human Services has established a "Privacy Rule." The Privacy Rule was created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide healthcare that is in your best interest. Part of your treatment may include photographs or videos.

We may desire to use photographs taken of you by our office for treatment, educational, and/or advertising purposes. However, prior to using any photographs for advertising purposes, we obtain consent from the patient or legal guardian. You may refuse to consent to the use or disclosure of your personal health information. This MUST be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information ("PHI"). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you review our privacy notice.

I hereby give consent for the Orthopedic Institute of North Texas to take and/or display photography and/or videos. The photography/video will be used for educational and/or advertising purposes by the Orthopedic Institute of North Texas and may be displayed within our office and/or the Orthopedic Institute of North Texas webpage, social media, and/or for training/educational purposes.

The physicians and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed. You may revoke this consent at any time in writing, except to the extent OINT has already used the photographs in reliance on it.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Relationship to Patient: **_____ Self** **_____ Guardian**

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1st, 2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website or request to speak with our HIPAA Compliance Officer.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency

circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, but not before September 1st, 2018. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You MUST make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at

The Orthopedic Institute of North Texas, PLLC

5575 Warren Parkway, Suite 115, POB#1

Frisco, Texas 75034

(p) 972-591-6468 | (f) 972-591-6469

info@oint.org

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed above. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat Patient without Parent/Guardian

In accordance with law, without a Parent/Legal Guardian present, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian.

If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

_____ _____

Minors Name **Date of Birth**

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name **Relation to child**

_____ _____

Name **Relation to child**

_____ _____

Name **Relation to child**

Limitations: Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

_____

□ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for: □ Date _____ OR □ Indefinitely, until written revocation.

Authorization: I request and authorize the Orthopedic Institute of North Texas and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize the Orthopedic Institute of North Texas and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited: medical evaluation, physical exam, radiographic exam, injections, x-rays, lab work, dressing changes/application. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____

Patient Name (please print)

_____

Parent or Legal Guardian (please print)

_____ _____

Signature of Parent or Legal Guardian **Date**

Consent for Text Message Communications

The Department of Health and Human Services has established a "Privacy Rule" under the Health Insurance Portability and Accountability Act (HIPAA). The Privacy Rule was created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information. As our patient, The Orthopedic Institute of North Texas ("OINT") respects the privacy of your medical information and is committed to protecting it. This form provides your written consent for OINT to communicate with you by text message regarding certain aspects of your care, including communications that may contain protected health information (PHI).

Risk of Text Message Communication

Text messaging is a convenient method of communication; however, we want you to be aware of the following risks associated with text message communications containing your protected health information (PHI):

- **Lack of Encryption**: Standard text messages are not encrypted and may be intercepted by unauthorized third parties during transmission.
- **Device Security**: Text messages may be stored on mobile devices that could be lost, stolen, or accessed by unauthorized individuals.
- **Network Vulnerabilities**: Messages pass through third-party carriers and may be susceptible to interception or unauthorized access.
- **Delivery Issues**: Text messages may not be delivered, may be delayed, or may be delivered to incorrect recipients due to technical issues.
- **No Guarantee of Privacy**: OINT cannot guarantee the security or privacy of any message once transmitted.

Despite these risks, if you wish to receive text messages from OINT, you must provide your explicit consent below.

Patient Consent and Authorization to Communicate via Text Messaging

I hereby authorize The Orthopedic Institute of North Texas and its employees, physicians, physician assistants, nurse practitioners, and other staff members to communicate with me via text message regarding:

☐ Appointment reminders and confirmations ☐ Pre-operative and post-operative instructions ☐ Test results and follow-up care instructions ☐ General health information and educational materials ☐ Billing and payment reminders ☐ Other: _____

Mobile Phone Number: (__) -

☐ I decline to receive text message communications from OINT.

By signing below, I acknowledge and agree that:

- I have read and understand the risks associated with receiving unsecured text messages containing my PHI.
- I voluntarily consent to receive text message communications from OINT as described above.

- I understand that I may revoke this consent at any time by replying “STOP” to a message or notifying OINT in writing.
- I understand that OINT will use reasonable safeguards to limit the PHI included in messages but cannot guarantee confidentiality once messages are sent.
- I will notify OINT if I change or deactivate my phone number or if my phone is lost or stolen.
- Text messages may be sent via automated systems, and standard message/data rates may apply.
- I expressly consent to receive automated text messages from OINT at the number provided above for the purposes I have selected.
- I understand that I may refuse to sign this form and still receive medical treatment, though I will not receive text messages.
- I understand that once PHI is transmitted via text message, it may no longer be protected under HIPAA if accessed by others on my device or carrier network.

If you have any objections to this form or questions about our privacy practices, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice and to request restrictions on the use of your PHI. A copy of OINT’s Notice of Privacy Practices is available upon request at the front desk.

Consent for Email Communications

The Department of Health and Human Services has established a “Privacy Rule” under the Health Insurance Portability and Accountability Act (HIPAA). The Privacy Rule was created to provide a standard for how certain healthcare providers obtain their patients’ consent for uses and disclosures of health information. The Orthopedic Institute of North Texas (“OINT”) respects the privacy of your medical information and is committed to protecting it. This form provides your written consent for OINT to communicate with you by email regarding certain aspects of your care, which may include information that qualifies as protected health information (PHI).

Risks of Email Communication

Standard email is not encrypted and may be intercepted or accessed by unauthorized parties. Emails may also be stored on servers or devices that are not secure, misdelivered, or delayed. Once transmitted, OINT cannot guarantee the security or privacy of an email.

Despite these risks, if you wish to receive emails from OINT, you must provide your explicit consent below.

Patient Consent for Email Communications

The Orthopedic Institute of North Texas (“OINT”) respects the privacy of your medical information and is committed to protecting it. This consent authorizes OINT to communicate with you by email regarding aspects of your care that may include protected health information (PHI). Please read carefully and sign below if you wish to receive email communications.

By signing below, I authorize OINT and its staff, including physicians, physician assistants, and nurse practitioners, to communicate with me via email regarding:

☐ Appointment reminders and confirmations ☐ Pre-operative and post-operative instructions ☐ Test results and follow-up care instructions ☐ General health information and educational materials ☐ Billing and payment reminders ☐ Other: _____

Email Address: _____

☐ I decline to receive email communications from OINT.

By signing below, I acknowledge and agree that:

- I have read and understand the risks associated with receiving unencrypted email communications containing my protected health information (PHI).
- I voluntarily consent to receive email communications from OINT as described above.
- I understand that I may revoke this consent at any time by notifying OINT in writing. Revocation will not affect emails already sent in reliance on this consent.
- I understand that OINT will use reasonable safeguards to limit the PHI included in email messages but cannot guarantee confidentiality once emails are transmitted.
- I will promptly notify OINT if my email address changes.
- I understand that OINT advises against using an employer-provided or shared email account, as others may have access to those messages.
- I understand that email should not be used for urgent or emergency matters. I will contact OINT by phone or call 911 as appropriate for emergencies.
- I understand that email subject lines should not include diagnoses or sensitive information.
- I understand that once PHI is transmitted via email, it may no longer be protected under HIPAA if accessed by others through my device, email service, or shared accounts.

If you have any objections to this form or questions about our privacy practices, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice and to request restrictions on the use of your PHI. A copy of OINT's Notice of Privacy Practices is available upon request at the front desk.

Consent Term and Revocation

This consent will remain in effect unless and until I revoke it in writing. Revocation will not affect any communications already made in reliance on this consent.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Relation to Patient: ☐ Self ☐ Parent ☐ Legal Guardian

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize text or email communications for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to receive text or email communications containing the patient's PHI. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

_____ _____

Witness **Date**

Code of Conduct

In an effort to provide a safe and healthy environment for everyone, the Orthopedic Institute of North Texas expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights and safety of other patients and staff.

The following behaviors are prohibited:

1. Making verbal threats to harm another individual or destroy property
2. Making menacing gestures
3. Attempting to intimidate or harass other individuals
4. Making harassing, offensive, or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication
5. Racial or cultural slurs or other derogatory remarks associated with, but not limited to race, language, gender or sexuality

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

By signing this consent form, you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.