DR. ANDREW MARTIN

Board Certified Orthopedic Surgeon

"KeepMoving...Life'sWaiting"

CONSENT FOR TREATMENT

Consent for Treatment: I hereby request and consent to the performance of such material, surgical, diagnostic and therapeutic procedures by AS Martin Orthopedics and its designated medical care personnel as they may deem necessary in connection with my care or the care of my minor child or dependent. I understand the explanation (s) given and I acknowledge that no guarantee can be given to me by anyone concerning the results or treatments, examination, or procedures.

Privacy Notice: I acknowledge review of the Health Information Privacy Notice for AS Martin Orthopedics disseminated on or after 12/01/2014.

Request (s) for Health Care Information: I authorize AS Martin Orthopedics and it designated medical care personnel to obtain from and for other release to AS Martin Orthopedics copies of my previous health information including medical records, images and test results to care for me or minor child or dependent.

Electronic Health Record: I have been made aware and understand that AS Martin Orthopedics and its designated medical care personnel use an Electronic Health Record. I authorize AS Martin Orthopedics to participate in a Health Information Exchange (HIE) and/or electronically share my health information or that of my minor child or dependent with other providers to serve medical care needs, in addition to exchanging message via email. I further understand that health information will remain protected as required by law.

Electronic Prescribing: I have been made aware and understand that AS Martin Orthopedics and its designed medical care personnel may use an information system which allows prescriptions and related information to be electronically sent and shared with my pharmacy. I understand that users of an electronic prescribing system will be able to see my information about medications I am already taking, including those prescribed by other providers; I give my consent to AS Martin Orthopedics and its designed medical care personnel to fax a prescription and/or electronically prescribe, also known as eprescribing.

Notice to Patients Regarding the Destruction of Health Care Records: Pursuant to NRS 629.051, I understand that medical records are retained for five years and then become subject to destruction by AS Martin Orthopedics unless the patient is age 22 or younger.

Payment Guarantee: I understand that I am financially responsible for all charges related to services and durable goods provided to me whether or not paid by insurance or other coverage. If charges are not paid upon request, I understand that appropriate collection measures may be initiated including an account balance sent to the collection agency.

Patient Financial Agreement: "I also acknowledge and agree that in the event I do not pay for services rendered, AS Martin Orthopedics may place my account with a collection agency. Per NRS 649.375 (2)(b), a collection fee of 50% will be added to the balance in the event the terms are not met and reasonable attorney fees and court costs incurred in collection of my past due account."

Please complete reverse side

Insurance Authorization and Assignment: I authorize AS Martin Orthopedics to release any medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPPAA release of protected health information standards. I assign to AS Martin Orthopedics provider of service all payments or benefits of any kind to which I or my minor child or dependent am entitled on account of the services and supplies rendered, including private insurance or any other health plan coverage. The assignment will remain in effect until revoked by me in writing. I request that payment of authorized Medicare benefits be made on my behalf directly to AS Martin Orthopedics provider of services and supplies.

Release of Responsibility for Personal Valuables: I have been made aware and understand that AS Martin Orthopedics and its designated medical care personnel provide no facilities for safekeeping of valuables. I do hereby release AS Martin Orthopedics and its designed medical care personnel provide from any responsibility due to loss of damage of any valuables that I, or anyone accompanying me, may bring to an office visit.

I, or my legal representative, certify that I have read this document, that it has been explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy it requested.
I hereby authorize that photocopies of this form to be valid as the original.

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Patient or Patient Legal Guardian/Authorized Representive (PRINT LEGIBLY)

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Relationship to Patient if Applicable

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Signature

_____

Date

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