NORTH HOUSTON ORTHOPEDICS AND SPORTS MEDICINE

PATIENT INFORMATION

Last name/ First Name:	DOB:

APPOINTMENT POLICY/LATE APPOINTMENTS

☐ Reserved appointment time in any specialist office is limited and valuable. It is extremely important that all patients honor their reserved appointments. Failure to do so deprives our other patients from receiving needed orthopedic care in a timely fashion. Our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment, (24 hours advance notification), will result in a **$30.00** fee being charged. The patient is solely responsible for payment of the charge. North Houston Orthopedics and Sports Medicine reserves the right to reschedule your appointment if you are more than 15 minutes late. This notice fulfills our obligation to notify you of the possibility of collection action if your account is not resolved within 30 days.

Initial: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

☐ I have reviewed this office's Notice of Privacy Practices that explains how my protected health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document and authorize the use and distribution as described. Initial: _____

HIPAA – AUTHORIZATION TO RELASE PROTECTED HEALTH INFORMATION

I give my authorization to release my protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities. I understand that North Houston Orthopedics may leave voice mail, send electronic correspondence or fax results pertaining to appointment information, financial information and/or treatment plans. I understand that I may withdrawal my consent at any time and will submit my request in writing to North Houston Orthopedics and Sports Medicine's privacy officer.

FOR MINORS ONLY: I _____(parent name), being the parent of the above listed patient give my authorization to release my child's protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities who are authorized to bring my child to his/her appointments.

Name:	**Relationship to patient:**	**Phone No.:**
Name:	**Relationship to patient:**	**Phone No.:**
Name:	**Relationship to patient:**	**Phone No.:**
Name:	**Relationship to patient:**	**Phone No.:**

I ACKNOWLEGE I HAVE BEEN INFORMED OF NORTH HOUSTON ORTHOPEDICS AND SPORTS MEDICINE OPERATING PROCEDURES. MY SIGNATURE AUTHORIZES MY PERMISSION TO CONTINUE CARE WITH NORTH HOUSTON ORTHOPEDICS AND SPORTS MEDICINE INCLUDING ANY OF ITS AFFILIATES OR ASSOCIATES.

Signature: _____ Date: _____

Witness: _____ Date: _____

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