

**GROSSKOPF ORTHOPEDICS, S.C.**

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**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

**PATIENT NAME:** \_\_\_\_\_

I, \_\_\_\_\_ (*patient name or legal guardian*), hereby request Grosskopf Orthopedics, S.C. to keep communications regarding my protected health information confidential. To accomplish this, please adhere to the following requests:

➤ You may release my protected health information to the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

➤ You may contact me and leave messages on voicemail (indicate preferred phone):

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

➤ **Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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**RECEIPT OF NOTICE OF PRIVACY PRACTICE AND PATIENT ADMINISTRATIVE AND FINANCIAL POLICY**

I, \_\_\_\_\_ (*patient name or legal guardian*) hereby acknowledge receipt of the *Notice of Privacy Practice* and the *Patient Administrative and Financial Policy*. **\*\*This includes the Missed Appointment / Late Cancellation Policy which states the patient will incur a fee of \$100 if an appointment is missed or a call is made on the same day of the appointment, to cancel.\*\***

The Notice of Privacy Practice provides detailed information about how Grosskopf Orthopedics, S.C. (the "Practice") may use and disclose my confidential information for Treatment, Payment and Operations purposes. I understand that the Practice has reserved the right to change privacy practices that are described in the Notice and that a copy of the revised Notice will be provided to me upon request.

I have read, understand, and agree to the Patient Administrative and Financial Policy guidelines.

*Assignment of Benefits: I hereby attest that I have provided current demographic and insurance information, and authorize release of information necessary for insurance claim filing and pre-certification by signing this statement. I also authorize payment of benefits to my physician and authorize Grosskopf Orthopedics, S.C. to release information for the purpose of insurance claims processing. I understand that I am financially responsible for the amount not covered by insurance.*

\_\_\_\_\_  
**PATIENT SIGNATURE** (*or patient representative if patient is a minor*)

\_\_\_\_\_  
**DATE**

*If you are not the patient, please specify your relationship to the patient:* \_\_\_\_\_