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: _____

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: _____