# J. PIETER HOMMEN, MD FAAOS

## CONSENT AND ACKNOWLEDGEMNET FORM

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize payment of Medicare or other insurance benefits otherwise payable to me for medical service rendered to me directly to Ortho Florida, J. PIETER HOMMEN, MD FAAOS. These benefits are not limited to Individual Policies, Group Policies, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits.

Where MEDICARE BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIV of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to J. PIETER HOMMEN, MD FAAOS, Ortho Florida, or any if its providers.

**THIRD PARTY BENEFIT COLLECTIONS**

I authorize Ortho Florida, (J. PIETER HOMMEN, MD FAAOS) to act in my behalf as attorney in fact in the collection of benefits from any responsible third party payor through whatever means may be deemed necessary, and the endorsement of benefit checks made payable to me and/or J. PIETER HOMMEN, MD FAAOS or any of its providers.

**RELEASE OF INFORMTION**

I authorize Ortho Florida, (J. PIETER HOMMEN, MD FAAOS) to release copies of information in their possession, as acquired in the course of my examination and/or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance and Medicare payment 1) This facility and its affiliates 2) Physician (Attending and consulting) 3) Utilization review agencies and auditors 4) Other allied health professionals.

**GUARANTEE OF PAYMENT**

I hereby understand that I am financially responsible for payment to Ortho Florida, J. PIETER HOMMEN, MD FAAOS for any changes not covered or allowable by my Insurance Company. This includes any denials of payment due to lack of medical necessity or pre-certification/authorization, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorney's fees if/when applicable.

**CONSENT TO TREATMENT**

I consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, anesthesia, laboratory procedures, and medications that may be performed, administered or rendered by or under specific or general instructions of my physician. I hereby voluntarily consent to rendering of medical treatment by J. PIETER HOMMEN, MD FAAOS and/or the medical staff, which may include routine diagnostic and/or surgical procedures, administration of injections, and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition

**APPOINTMENT REMINDERS**

I acknowledge that this practice/facility may call for appointment reminders and/or cancellations. I authorize the use or disclosure medical information to contact you as a reminder. This contact may be by phone, in writing, e-mail or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and/or objections t this policy, please inform us.

**CONSENT TO PHOTOGRAPH**

I authorize the J. PIETER HOMMEN, MD FAAOS and its affiliates to take pictures of my medical or surgical procedure(s) and condition(s) and to the use of such pictures for treatment, scientific, educational, or research purposes.

**USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my health care, J. PIETER HOMMEN, MD FAAOS originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, the J. PIETER HOMMEN, MD FAAOS may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that J. PIETER HOMMEN, MD FAAOS reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should J. PIETER HOMMEN, MD FAAOS change their notice, I have the right to obtain a copy of any revised notice.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure of these permitted uses, including disclosures via fax or email.

I acknowledge that I have read and reviewed the NOTICE OF PRIVACY PRACTICES and I am in agreement of such.

I acknowledge that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to these provisions individually and collectively.

**Patient's Signature**: ______________________________ **Date**:________________

**Print Name**: ______________________________