

Last Name: _____ First Name: _____ M.I. : _____

CONSENT FOR TREATMENT: I voluntarily consent to care by Cornerstone Orthopaedic Trauma Associates, its employees and independent contractors, as well as physicians, physician assistants, nurse practitioners, and other healthcare workers who may be independent practitioners and not employees or agents of Cornerstone Orthopaedic Trauma Associates. I understand that independent practitioners and contractors perform services at Cornerstone Orthopaedic Trauma Associates, and Cornerstone Orthopaedic Trauma Associates is not responsible for the actions of these healthcare providers. Such care includes, but is not limited to, routine x-rays, laboratory and other diagnostic procedures, medical treatment, and other medical services as necessary in the treating physician's (or designee's) judgment. This may include the taking of photographs and video that may be useful in diagnosing, documenting, or treating my condition or that may be useful for medical education or quality improvement purposes. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatments or examinations. As a patient of Cornerstone Orthopaedic Trauma Associates, I understand that individuals being trained in health care may participate in my care. I also understand that health care vendors may be present during my care. I consent to their presence and assistance under general supervision according to Cornerstone Orthopaedic Trauma Associates policy.

MEDICATION HISTORY: I give Cornerstone Orthopaedic Trauma Associates permission to collect information my pharmacy and health care plan have disclosed. This includes information about filled prescriptions at any pharmacy or covered by any health insurance plan. This may not include over the counter medications, herbal supplements, herbal remedies, medications not reported by the pharmacy or my health care plan, or medications I paid for out of pocket. This medication history may not be completely accurate, so it is very important for me to point out any errors or omissions in my medication history.

TELEHEALTH CONSENT: I understand that telehealth services may be part of my care at Cornerstone Orthopaedic Trauma Associates if my provider determines that such services are appropriate for my condition. Telehealth services are health care services delivered by a provider at a different location from the patient via two-way audio and video communications and/or by the electronic transmission of patient information. Cornerstone Orthopaedic Trauma Associates will identify the telehealth provider and the provider's credentials whenever I receive such services. Cornerstone Orthopaedic Trauma Associates has established security measures in relation to its use of telehealth technologies, including data encryption, secure networks, and password protected computers and applications. I understand that despite those measures, there are risks to privacy whenever personal information is transmitted and/or stored electronically. I also understand that information may be lost due to technical failures. Knowing these risks, I voluntarily consent to receive telehealth services to the extent they are determined to be appropriate by my provider.

PERSONAL PROPERTY: I understand Cornerstone Orthopaedic Trauma Associates is not responsible for loss or damage to my personal property brought to Cornerstone Orthopaedic Trauma Associates.

FINANCIAL CONSENT: I agree to be responsible for payment of all Cornerstone Orthopaedic Trauma Associates charges. I also agree to be responsible for all professional fees. I understand that I am responsible for all charges and fees whether they are covered by insurance or not. I will submit applications to federal, state and county programs when appropriate. I understand Cornerstone Orthopaedic Trauma Associates and its independent practitioners will bill me, my family and/or other responsible parties for services provided.

ASSIGNMENT OF INSURANCE PAYMENT: I hereby authorize my insurer to pay Cornerstone Orthopaedic Trauma Associates and its independent practitioners directly for their respective claims for reimbursements. This assignment is effective only if allowed by my insurance plan and accepted by Cornerstone Orthopaedic Trauma Associates and its independent practitioners. I understand claims may be made upon any health insurance policy or policies providing coverage for care and treatment and for physician services rendered.

