CORNERSTONE ORTHOPAEDIC
TRAUMA ASSOCIATES

Consent for Outpatient Services

Full Name: _____ Date of Birth: _____ / _____ / _____

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.

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. I understand that failure to pay outstanding balances will result in submission to an outside collection agency. I also understand that in addition to Cornerstone Orthopaedic Trauma Associates there may be multiple providers and/or facilities involved in my care and that I may be billed separately for their services.

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.

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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.

AUTOMATED MESSAGES: To the extent consent is required by the Telephone Consumer Protection Act or other applicable law, I hereby authorize Cornerstone Orthopaedic Trauma Associates and its designees to deliver messages to me through the use of an automatic telephone dialing system or an artificial or prerecorded voice at any telephone number I have provided to Cornerstone Orthopaedic Trauma Associates. I am not required to agree to receive such automated calls, and my agreement is not a condition to receiving items or services from Cornerstone Orthopaedic Trauma Associates. Cornerstone Orthopaedic Trauma Associates does not waive and expressly reserves the right to contact me by any means for any purpose as otherwise permitted by law.

PATIENT RIGHTS AND RESPONSIBILITIES: I have been given the opportunity to review Cornerstone Orthopaedic Trauma Associates' Patient Rights and Responsibilities, and I understand my rights as described in that document.

_____	_____	_____
Signature of Patient or Legal Guardian	*Date*	*Time*

PATIENT IS UNABLE TO SIGN

Please explain: _____

Name: _____ Relationship to Patient: _____

_____	_____	_____
Signature	*Date*	*Time*