

Orthopedic Associates of Lancaster, Ltd

Patient name _____ Account # _____

Voluntary Consent to Treatment

I do hereby voluntarily consent to permit any associated physician or assistant of Orthopedic Associates of Lancaster, LTD to perform an examination and any diagnostic procedures, including such medical/surgical procedures, as are necessary or advisable in their judgment for my medical care

Signature of patient, power of attorney, or guardian, if minor

Date

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received the Notice of Privacy Practices for Orthopedic Associates of Lancaster, Ltd.

Signature of patient, power of attorney, or guardian if minor

Date

Email Address: (optional) _____
(This would be used to notify you of any education programs presented by our physicians)