

Patient Name: _____
DOB: _____
MRN: _____

VOLUNTARY CONSENT TO TREATMENT (Minors <18 years of Age)

Consent can only be given by a parent/guardian or LEGAL Power of Attorney (POA). If not present, please give form to OAL Staff

I do hereby voluntarily consent to permit any associated physician or assistant of Orthopedic Associates of Lancaster (OAL) 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.

_____ Initial

BILLING GUARANTOR INFORMATION & AGREEMENT

Billing Guarantor: _____ Guarantor DOB: _____ Relationship: _____

Billing Address: _____

Billing Agreement: I understand that the billing guarantor is financially responsible for charges not covered by insurance, including applicable copays, deductibles, and coinsurance. I agree to provide accurate insurance and billing information. _____ Initial

FUTURE VISIT CONSENT (Patient <18 years of Age)

This section is optional, but can only be filled out by an accompanying parent/guardian or LEGAL POA if physically present

☐ Minor can be seen at subsequent follow-up visits if accompanied by:

1) _____ Relationship: _____

2) _____ Relationship: _____

☐ Minor can be seen for subsequent follow-up visits by his/herself. _____ Initial

VERBAL CONSENT (Patient <18 years of Age)

This section to be filled out by OAL Staff if parent/guardian or LEGAL Power of Attorney is not physically present

Verbal consent was obtained from:

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian DOB: _____ Consent obtained by (circle): Phone email letter

Signature Patient Services Rep: _____ Date: _____ Time: _____

ACKNOWLEDGMENT OF RECEIPT OF AUDIO/VIDEO RECORDING POLICY & NOTICE OF PRIVACY

PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received the Audio/Video Recording Policy & Notice of Privacy Practices for OAL.

Signature

Print Name

Date