ACKNOWLEDGMENT AND CONSENT

I understand that Advanced Orthopedic & Sports Medicine Institute, LLC will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practice and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of this practice and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised notice. I also understand that a copy or a summary of the most current version of this Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand I have the right to request this practice to restrict the uses and disclosures of my health record information for treatment, payment and operations, or restrictions involving my care or payment related to my care. Under Federal Law this office is not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

By signing below, I agree that I have reviewed and understand the information noted above.

Signature____ Date______________________

Relationship to Patient____