**Greiner Orthopedics Practice Consent**

**Notice of Privacy Practices**

I acknowledge that I have received the practice’s Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information of its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. To the extent permitted by law I consent to the use and disclosure of my information for the purposes described in the practice’s Notice of Privacy Practices.

**Release of Information**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information regarding a prior admission(s) at any affiliated facilities may be made available to subsequent any affiliated admitting facilitates to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes’ and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes the information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including but not limited to, blood borne diseases, such as HIV and AIDS.

**IMPORTANT**

**Disclosures to Friends and/or Family Members**

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have relationship.

***IMPORTANT***

**Text/ Voice/ Email Communication from our practice**

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you miss an appointment or do not contact the office (816-317-5070) with 24 hours prior to the scheduled visit time it will be consider a missed appointment and a $50.00 no-show fee can be assessed to you. This applies to “late cancellations” and “no-shows”, this $50.00 fee will not be covered by any insurance.

Since missing appointments takes care from other patients that could have utilized the time period it will be up to the practice’s discretion to terminate care after one or more “no show” or “late cancellation” visits. Termination from care will be delivered in letter form via postal services.

The patient is acknowledging that any imaging brought in for a visit will only be held for 7 business days, then it will be permanently destroyed. Greiner Orthopedics is not responsible to for this part of your medical record.

The patient is acknowledging that the practice only prescribes narcotic pain medication up to 90 days after surgery, if further pain control is needed the patient will need to contact their primary care provider for further pain management.

Greiner Orthopedics does not refill any pain medications after normal clinic hours or on the weekend, allow 24 hours for any refill request to be addressed.

**Prescription Pick-up**. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician’s office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

Family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for History of Prescriptions.** The patient is acknowledging that Greiner Orthopedics will utilize electric prescription software to view and add to the current medication list to your chart. This will allow Greiner Orthopedics to electronically send prescriptions to the pharmacy you have provided.

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_