RECEIPT OF NOTICE OF PRIVACY PRACTICE
WRITTEN ACKNOWLEDGEMENT FORM

☐ I have received a copy of Southern Oregon Spine Care’s Notice of Privacy Practices.

☐ I have been offered but refused a copy of Southern Oregon Spine Care’s Notice of Privacy Practices.

Signature of patient or legal guardian: ____________________________

Printed name of patient or legal guardian: ____________________________

Date: ____________________

FOR INTERNAL PURPOSES ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevents us from obtaining acknowledgement
☐ Other (please specify) ____________________________________________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please turn over…->
PERMISSION TO RELEASE INFORMATION & ASSIGNMENT

I have read and agree to the following:

1. Provide a current, personal and private email address that only you have access to. By providing an email address, you agree to have Southern Oregon Spine Care provide you with secure access to your health information.

   Email address: __________________________________________________________ (Not Required)

2. Assign to the Physicians at Southern Oregon Spine Care all payments to which I am entitled for medical and surgical expense related to the service performed by them, and direct that checks for such services be made payable to them. ______ Initial

3.Authorize the above physicians to release such information as may be required by my attorney and/or my insurance company and/or referring doctor. ______ Initial

4. I understand that I am responsible for the payment of the bill, regardless of whether the charges may be covered by insurance in or out-of-network, or also be the responsibility of some other party. This includes supplies that I may receive that are not covered by Medicare or other plans. ______ Initial

5. If the problem for which you are seeing one of our doctors involves litigation, as may result from an automobile accident or liability, be advised that we do not wait for payment until the litigation is settled. We will accept monthly payments on your account excluding worker’s compensation. ______ Initial

6. EPrescribing is defined as a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. I hereby provide informed consent to Southern Oregon Spine Care to enroll me in the ePrescribe Program, if I am not already enrolled. ______ Initial

7. I agree that Southern Oregon Spine Care may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. ______ Initial

8. I authorize Southern Oregon Spine Care and its staff, to leave detailed messages at the primary phone number provided. ______ Initial

9. A 24 hour notice is required for any cancellations or reschedules. If you no-show for your appointment 2 times, you may not be able to reschedule. If you’re more than 10 minutes late to your appointment it will be cancelled. ______ Initial

10. If you are unable to pay your balance due to a large amount, we may set you up on a payment plan to be satisfied within a maximum of 90 days. If you default on your payment plan the agreement will be void and the account will automatically be turned over to a collection agency without further notification to you. Once set up on a payment plan any additional office visits must be paid in full at the time of service or appointment will be cancelled. ______ Initial

11. I understand that my information will be shared with SOSC’s third party billing service(s) providers, Physource Billing Solutions and Specialty Care Management Services ______ Initial

   Signature of patient or legal guardian: _________________________________

   Date: _____________________