# GENERAL CONSENT AGREEMENT

Dubuque Orthopaedic Surgeons, PC
1500 Delhi Street, Suite 4200
Dubuque, IA 52001

**CONSENT TO TREATMENT**

I consent to receive services, including examination, which may include, but are not limited to, laboratory procedures, x-ray examinations, medical treatment or procedures, or clinic services rendered to the patient under general and special instructions of the patient's treating practitioner at **Dubuque Orthopaedic Surgeons, PC** (the "PRACTICE"). I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I will be provided verbal treatment options for necessary services; however, I understand that during treatment it may be necessary to change or add procedures because of conditions found while working that were not discovered during examination. I give my permission to my treating provider to make any/all changes and additions as necessary.

**TREATMENT OUTCOMES**

I understand that the practice and my treating provider cannot guarantee treatment outcomes. I am responsible for reviewing the treatment plan and asking any questions I may have prior to receiving treatment. I have the right to accept or reject treatment recommended by my treating provider. By consenting to my provider's treatment plans, I acknowledge that I accept known risks and complications of such treatments. It is my responsibility to fully inform the provider of my medical history, all medications or other drugs that I am using and otherwise truthfully answer all questions related to my care. It is also my responsibility to follow my provider's pre- and post-treatment instructions. I acknowledge that failure to comply with these requirements may increase the chance of poor outcomes.

**CONSENT TO RECEIVE COMMUNICATION**

I agree that, when I provide my landline or cell phone number(s), I am giving you express consent to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages to voicemail or text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of the practice. I will be responsible for all data and other charges for text or email messages. Providing a telephone or cell number or email address is not a condition of receiving services. This consent to receive voicemails, emails and text messages applies to future communications unless I request a change in writing, by clicking an unsubscribe link provided in emails, or by replying STOP to all text communications.

I further acknowledge that these communications may contain information that is protected under state and federal privacy laws, and that my consent means that the practice may use the methods I identify below to contact me about appointments, my treatment, payments and other information that may contain protected health information. The practice will use all reasonable efforts to minimize the amount of protected health information disclosed and otherwise protect my personal data; however, I am aware that such communications will not be encrypted and that there may be some risk that such messages may be read or accessed by a third party. By signing below my acceptance to receive communications via text, email or voicemail, I am agreeing that I have been informed of this risk and that I still prefer to receive communications in these manners.

____ I APPROVE ____ I DECLINE - Authorization to receive *automated* appointment confirmation communication.

Please select **one** way you would like to receive automated communication: ☐ *TEXT* ☐ *EMAIL* ☐ *VOICEMAIL*

Email Address: ________________________________________

I understand that declining automated appointment reminders does not decline consent to live calls from our practice regarding scheduling or scheduled appointments, my services, or my bill.

**CONSENT TO ELECTRONIC PRESCRIBING**

I authorize an electronic prescribing network to release my medication refill history to the practice for the purpose of continued treatment.

**CONSENT TO UPDATE BILLING ADDRESS**

I understand that it is my responsibility to inform the practice of a change of address within 14 days of moving. Failure to do so could result in returned billing statements and could cause your account to be sent to a collection agency if your account becomes past due.



**Please continue to reverse/page 2**

## CONSENT TO SCHEDULING AND APPOINTMENTS

I understand that it is my responsibility to change or cancel appointments I can no longer keep at least 2 business days prior to the scheduled appointment. I further understand that multiple short notice cancellations may result in my dismissal as a patient.

## PAYMENT FOR SERVICES

I understand that I am responsible for all charges for the care I receive. If I do not have medical insurance coverage, I will pay all amounts for which I am responsible in full, in advance of treatment. It is my responsibility to provide accurate and up-to-date information regarding my health insurance coverage. I agree that payments from my health plan may go directly to the practice. If I should receive the payments, I understand that I will be responsible for immediately paying such amounts to the practice. Depending on the type of coverage I have, my responsibilities are as follows:

***IN NETWORK*:** If my treating provider is in-network with my health insurance plan, I will be billed pursuant to the terms of my insurance policy and my providers contract with the insurer. Even when the practice and my treating provider are a participating provider with my insurance, I understand that the practice may hold me responsible and collect all charges in any one of the following situations:

- When I choose to have a service that my health plan covers but I do not obtain the required referral or prior authorization from my health plan.
- When I choose not to use my health plan and agree to pay for services myself.
- When I receive services that are not covered under my health plan

***OUT OF NETWORK***: If my treating provider is not a participating provider with my insurance, I will be required to pay for all treatment in full, in advance. The practice may file for insurance coverage as a courtesy and apply anything they pay towards my account. If payment from my insurance company results in an overpayment on the account, I will be reimbursed by the practice.

**ALL PAYORS**: Regardless of whether my treating provider is participating provider, I will be responsible for any deductibles, co-payments, the costs of uncovered services and any other part of the bill that my health plan says I must pay. If for any reason I do not pay, in full, the amounts I owe the practice, I will also reimburse the practice for all costs of collection, including legal fees and a 25% collection fee of the total amount submitted to the collection agency. I also agree the practice may charge me interest equal to 1% monthly on all balances that have been outstanding for thirty (30) days or more. Should we receive a bounced check back, due to non-sufficient funds, the practice is permitted to charge you a returned-check fee between $20-$40, or a percentage of the check amount.

## GUARANTOR

If you are signing this consent as a guarantor you are accepting financial responsibility to pay for the patient's bill, which will be mailed to your home address. If the patient is a child, the responsible party is the guarantor whom the child primarily lives with. The practice does not take responsibility for handling custody agreements or divorce decree's when it comes to financial responsibility.

## RELEASE OF INSURANCE BENEFITS

I agree to be responsible for all charges for services and materials not paid by my health benefit plan, unless prohibited by law or the treating provider has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to Dubuque Orthopaedic Surgeons, PC's use and disclosure of my protected health information to carry out payment activities in connection with insurance claims. I hereby authorize and direct payment of the insurance benefits otherwise payable to me, directly to Dubuque Orthopaedic Surgeons, PC.

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**MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ THIS CONSENT AGREEMENT AND AGREE TO THE STATED ITEMS AS THEY HAVE BEEN OUTLINED. I HAVE BEEN GIVEN THE OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS AGREEMENT AT ANY TIME. I FURTHER ACKNOLEDGE THAT I MAY REVOKE MY CONSENT TO ALL OR ANY PART OF THIS CONONSENT AGREEMENT AT ANY TIME BY DOING SO IN WRITING.**

______________________________ PATIENT NAME (PRINTED)

______________________________ DATE

______________________________ SIGNATURE OF PATIENT/LEGAL RESPRESENTATIVE

______________________________ GUARANTOR NAME (PRINTED)

☐ YES ☐ NO **I would like to receive a copy of this consent, please select one.**

______________________________ RELATIONSHIP TO PATIENT