CENTRAL COAST ORTHOPEDIC MEDICAL GROUP

Patient Policies and Consents

By initialing and signing below, you are acknowledging that you have received, read, and agree to Central Coast Orthopedic Medical Group's (CCOMG) policies and consents as listed below:

Please find online at CentralCoastOrtho.com or ask reception for a printed copy.

_____ **ePrescribing**: I acknowledge that I received and agree that CCOMG
Initials may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ **Forms Fee Policy**: I acknowledge that I received, read and understand the policy regarding fees
Initials for the completion of State Disability forms and any other form that requires completion by the physician.

_____ **Financial Policy**: I have received, read, understand and agree to CCOMG's Financial Policy.
Initials

_____ **Notice of Privacy Practices**: I hereby acknowledge the receipt of the Notice of Privacy Practices.
Initials Access to the Privacy Practices has been provided to me.

Patient Signature/Responsible Party **Printed Name** **Date**

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996, you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are electing to designate an individual(s) as your personal representative. You may revoke this designation at any time by signing and dating the revocation portion of your copy of this form and returning it to this office.

I, _____(print your name here), hereby nominate the following person/s to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me, i.e. appointment/billing questions and/or medical records request:

Name	**Phone Number**	**Relationship to the Patient**
_____	_____	_____
_____	_____	_____

When acting on my behalf, my representative is restricted to the following functions: _____.

-or-

☐ I do not wish to designate a personal representative.

_____ _____

Patient Signature **Date**