CONDITIONS OF TREATMENT
TRI-COUNTY ORTHOPEDIC & SPORTS MEDICINE
an affiliate of HUGH CHATHAM MEMORIAL HOSPITAL

1. **Release Of Information:** By signing below, I give permission for Hugh Chatham Memorial and its hospital affiliated physicians to release information about my care, treatment, and medical bill to my insurance companies, professional standards review organizations, or to any person or organization authorized by law to review my records. In addition, the hospital may release my medical records to any person or provide information to other health care providers involved in my care, and I consent to such releases for continuity of care.
2. **Consent to Care:** I am presenting myself for medical care and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of Tri-County Orthopedic & Sports Medicine, and by its medical staff, or to their designees, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition. I understand that I have not been given any guarantee about the effect of the examination(s) and/or treatment(s) I receive.
3. **Assignment of Insurance Benefits:** By signing below, I authorize Tri-County Orthopedic & Sports Medicine to bill my insurance company(ies) and to accept payment directly from the insurance company(ies). I understand that I will be responsible for the balance of the bill after the insurance company(ies) has(have) paid.
4. **Financial Agreement and Payment Guarantee:** If I do not pay my bill when my portion is due, Tri-County Orthopedic & Sports Medicine may refer my account to an attorney or a collection agency. If this happens, I will be responsible for paying the attorney's fees and collection expenses.
5. **For Medicare/Medicaid Beneficiaries Only:** I have provided information about my eligibility for Medicare (Social Security Act Title XVIII funds) and/or Medicaid (Social Security Act XIX funds). I certify that this information is correct. I request that Medicare/Medicaid payments for the services be made directly to Tri-County Orthopedic & Sports Medicine. I authorize the Tri-County Orthopedic & Sports Medicine to release information needed to determine my entitlement to Medicare/Medicaid benefits to the Health Care Financing Administration, the North Carolina Division of Medical Assistance, or any person acting on their behalf.
6. I have received a copy of Tri-County Orthopedic & Sports Medicine's Notice of Privacy Practices.
7. Hugh Chatham Memorial Hospital does have contractual arrangements with various training institutions. From time to time students may be involved in your care.
8. **Telephone Consumer Protection Act (TCPA) –** I acknowledge and agree by signing below that Tri-County Orthopedic & Sports Medicine and any affiliates or vendor thereof, including collection or billing companies, **may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account**, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Dialing System (ATDS) or prerecorded message. I also agree that I will notify Tri-County Orthopedic & Sports Medicine if I have given up ownership or control of any such telephone number.
9. **Consent to Photograph**: The taking of still or moving pictures involving Patient medical or surgical procedures or to document a physical condition, or for scientific, educational, or research purposes, is hereby approved and consented to by the Patient, provided that the Patient is not specifically identified whether by writing or depiction unless the photograph is to be part of the medical record for treatment purposes.
10. **In the event of a needle stick injury** to any health practitioner or employee of Tri-County Orthopedic & Sports Medicine sustained during my treatment, I CONSENT to blood samples being taken for the sole purpose of determining whether I have a transmissible disease (eg. Hepatitis B, Hepatitis C or HIV) that may be a significant health risk to that employee. Your test results will remain confidential to you and your medical practitioner.

I certify that I have read the above, and am the patient, or am duly authorized by the patient as patient's general agent to execute the Above and accept its terms. All guarantors certify that they have read the above and accept these terms.

I understand this authorization is good for 12 months from the date signed.

_____ _____

Patient Signature/Date/Time Power of Attorney/General Pt. Agent

_____ _____

Guarantor Witness

_____ _____

Interpreter or Spanish Translation Used Relationship to Patient