PRESTIGE ORTHOPAEDICS
& SPORTS MEDICINE

Christopher E. Urband, M.D.
11939 Rancho Bernardo Rd. Suite 115
San Diego, CA 92128
P: (858) 705 - 6130
F: (858) 400 - 4080

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Printed Name

HIPAA Privacy Rule of Patient Authorization Agreement

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my healthcare
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purpose and to the parties designated by me.

________________________________   __________________________

Patient Signature   Date

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Release of Information Agreement

The following form:

- Explains responsibility for fees and releases your information as needed to process medical billing claims (i.e. with your insurance providers(s)).
- Authorizes payments to be paid directly to Christopher E. Urband, MD and Prestige Orthopaedics and Sports Medicine, Inc.
- Releases your information to be released to other parties as defined by you.

RELEASE OF INFORMATION

*****We will give you assistance in processing your insurance claim with your primary insurance provider, however, you must understand that you are responsible for payment for all professional services and/or collection agency fees. *****

RELEASE OF INFORMATION AUTHORIZATION: I authorize the release of any medical information necessary to process claims to my insurance company. I agree that a photographic copy of this authorization shall be as valid as the original. If the patient is a minor, the signature found below shall be that of the patient's parent, guardian, or conservator.

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payment directly to Dr. Christopher E. Urband and Prestige Orthopaedics and Sports Medicine, Inc. of the Medical Expense Benefits otherwise payable to me, but not to exceed my indebtedness to said physician on account of the enclosed charge.

PERSONAL RELEASE OF MEDICAL INFORMATION

I authorize the following person(s) to discuss or be provided information related to my medical care including billing matters. (This does not include medical personnel and insurance companies)

__________________________________ ___________________________

Patient Signature Date

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Acknowledgement of Form Fee

Prestige Orthopaedics and Sports Medicine, Inc. has a $25 mandatory fee for the completion and/or submission of all forms which do not pertain directly to medical care. This includes forms relating to government functions, disability, leave of absence, insurance, travel, and many others. Payment of this form-fee is required before these forms will be completed and/or submitted, and still applies to forms which have been submitted prior to collection of the fee. Failure of the office to collect this fee will not signify or mean that the fee does not apply.

Agreement:

With my signature or signature of a guardian below, I acknowledge that I understand this policy and I am requesting that the office complete and/or submit forms on my behalf. I understand that I will be responsible for payment of the $25 fee as stated.

_________________________________ ___________________________

Patient Signature Date

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<u>No Show/ Late Cancellation Policy</u>

A "no show" is missing a scheduled appointment. A "late-cancellation" is cancelling an appointment without calling to cancel within 24 hours of an office appointment or 72 hours in advance of a procedure.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

A charge of $75 will be charged for each no show or late cancellation of an office visit appointment if less than 24 hours' notice is given.

Agreement:

With my signature or signature of a guardian below, I acknowledge that I understand this policy. I understand that I will be responsible for payment of the $75 fee as stated.

_________________________________ ___________________________

Patient Signature Date