LAKE ORTHOPAEDIC ASSOCIATES, INC.

Mentor: (440) 352-1711
Willoughby: (440) 942-1050

Please complete this form and hand carry it to your appointment.

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below (the "Patient"), I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Lake Orthopaedic Associates, Inc. (referred to as "Lake" in this form).

IMPORTANT NOTE: Completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Lake will review the Patient's health history and conduct an initial evaluation to determine whether the Patient is a suitable candidate and whether the practice will accept the Patient as a patient.

Consent to Health Care Services: I am requesting health care services be provided to the Patient at Lake. I voluntarily consent to all medical treatment and health care-related services the physicians and staff at Lake consider to be necessary for the Patient, including, but not limited to, diagnostic and therapeutic procedures. I authorize Lake to obtain my prescription history from an external source.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between Lake and a third-party payor, and in consideration of all health care services rendered or about to be rendered to the Patient, I agree to be financially responsible and obligated to pay Lake for any balance not paid under the "Assignment of Benefits/Third-Party Payors" paragraph below, at the current rates established by Lake.

Assignment of Benefits/Third-Party Payors: In consideration of all health care services rendered or about to be rendered to the Patient, I hereby assign to Lake all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payors of an amount not exceeding Lake's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third-party payors, and other third-parties. A list of charges is available upon request. I consent to any request for review or appeal by Lake to challenge a determination of benefits made by a third-party payor. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payor.

Disclosure of Health Information: I have received a copy of Lake's Notice of Privacy Practices which explains how Lake may use and disclose confidential health information that identifies me or the Patient. I consent to Lake's use and disclosure of health information about me or the Patient as described in the Notice of Privacy Practices. In doing so, I consent to the release of my or the Patient's health information and financial account information to all third-party payors and/or their agents that are identified by Lake, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent Lake or provide assistance to Lake for the purposes of securing payment from all parties who are potentially liable for payment for my or the Patient's health care.

Communication: I consent, on the cellular phone and/or other telephone number(s) provided on this form below or updated at a later time, to calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from Lake and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or third-parties who may act on Lake's behalf. Such calls may be related to any purpose, including those related to any care rendered to the Patient. I further consent to Lake contacting me via the email address provided on this form below for purposes related to my care. I understand this consent to communications is not required to receive services from Lake and that charges from my telephone service provider may apply.

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PATIENT ACKNOWLEDGEMENT AND CONSENT FORM (continued)

CONSENT TO DISCLOSE MEDICAL INFORMATION

Authorized Person(s): I hereby authorize Lake to release or discuss details of my care, treatment, and billing, and to contact in case of emergency, the following person(s) (spouse, parent, friend, etc.):

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

If assigned a power of attorney, identify the name of the person: _____

☐ **DO NOT DISCLOSE MY MEDICAL INFORMATION TO ANYONE.**

Revocation: I understand I can revoke any of the authorizations or consents contained in this form in writing at any time, except to the extent Lake has already relied upon such authorization or consent.

By signing below, I am indicating I have reviewed, acknowledge, and consent to the terms described above.

Printed Name of the Patient (**or** Responsible Party if not the Patient)		Responsible Party's Relationship to the Patient	
Signature of Patient or Responsible Party	Date	Print Name	Phone Number
Updated Signature	Date	Print Name	Phone Number
Updated Signature	Date	Print Name	Phone Number
Updated Signature	Date	Print Name	Phone Number
Updated Signature	Date	Print Name	Phone Number
Updated Signature	Date	Print Name	Phone Number
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PATIENT REGISTRATION

PATIENT'S EMAIL	PHARMACY NAME AND ADDRESS	PHARMACY PHONE NUMBER

PATIENT'S LAST NAME	FIRST	MIDDLE	NICKNAME, IF ANY	AGE

IS PATIENT A STUDENT? YES ❒ NO ❒	NAME OF SCHOOL:	FULL TIME ❒ PART TIME ❒

PATIENT'S STREET ADDRESS	APT/LOT#	CITY	STATE	ZIP

HOME PHONE NUMBER	CELL PHONE NUMBER	SEX: MALE ❒ FEMALE ❒	DATE OF BIRTH
LEAVE MESSAGE: YES ❒ NO ❒	LEAVE MESSAGE: YES ❒ NO ❒	SOCIAL SECURITY NUMBER	

MARITAL STATUS: SINGLE ❒ MARRIED ❒ WIDOWED ❒ DIVORCED ❒ SEPARATED ❒	LANGUAGE	RACE	ETHNICITY: HISPANIC ❒ NON-HISPANIC ❒

PATIENT'S EMPLOYER & OCCUPATION	FULL TIME ❒ PART TIME ❒ RETIRED ❒	BUSINESS PHONE	ARE CALLS ALLOWED? YES ❒ NO ❒

SPOUSE'S NAME	SPOUSE'S PHONE NUMBER

RESPONSIBLE PARTY'S NAME (IF A MINOR)	ADDRESS	HOME PHONE

WORK PHONE	BIRTHDATE	EMPLOYER

POLICY HOLDER FOR INSURANCE	ADDRESS

PHONE NUMBER	BIRTHDATE	EMPLOYER

REFERRING PHYSICIAN: _____

ADDRESS: _____

_____

PHONE: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

_____

PHONE: _____

INSURANCE INFORMATION (PLEASE WRITE NAMES OF INSURANCE COMPANIES)

PRIMARY: _____

SECONDARY: _____

DOES THE PATIENT HAVE AN ADVANCE HEALTH CARE DIRECTIVE OR LIVING WILL? YES ❒ NO ❒