TUCSON ORTHOPAEDIC INSTITUTE

TOI Office Use Only

Patient Medical Record Number: ________________________ Therapist: _____________

Consent to Treat

By signing this form, I (**patient name): ________________________________**consent to treatment by Tucson Orthopaedic Institute (TOI) providers.

Acknowledgement of Payment Policies/Insurance Release

I understand TOI will file insurance claims on my behalf, when applicable, and that my payment benefits will be paid directly to the practice. Any remaining balance amounts is my responsibility. I further understand that I will be responsible for all attorney fees incurred by the practice should collection efforts have to be invoked for account balances. **Initials:_________**

Authorization for Voicemail

I authorize physicians and staff members of Tucson Orthopaedic Institute to leave detailed messages pertaining to my medical care on my home or mobile phone. I know it is my responsibility to ensure I have accurate contact information on file with TOI:

Home Phone: ___________________________ Mobile Phone:___________________________

Authorization for Email: If you do not wish communication in this method, please leave blank.

I authorize the physicians and staff members of TOI to e-mail me directly. I understand that TOI will make every effort to ensure the secure transmission of information sent; but I, as the patient, take full responsibility for all compromises to my healthcare information transmitted in this manner: **E-mail:____**

Authorization to Release Information (Family/Friends or Doctors)

I authorize TOI to release and communicate my healthcare information with the following individuals:

Name	Relationship	Phone Number

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I can request a copy of the notice of Privacy Practices for Tucson Orthopaedic Institute, PC. TOI reserves the right to modify the privacy practices outlined in the notice. **Initials:_________**

Compliance Policy

It is extremely important for you to keep your appointments as scheduled and arrive on time for your appointment; if you are 15 minutes or later to your appointment, you may be rescheduled. If for any reason an appointment must be cancelled or changed, we ask that you comply with the following protocol: Failure to provide 24 hour notice or my inability to attend an appointment greater than two (2) times during a course of care can result in discharge from physical therapy and/or referral back to my MD for non-compliance with my treatment plan. **Initials:_________**

AZ State Statute: A.R.S. §32-1401(27) (*ff*) Knowingly failing to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the provider has a direct financial interest in a separate diagnostic or treatment agency or in non-routine goods or services that the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis.

TOI supports this law, as it helps patients make reasonable financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised that we have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services through TOI PT affiliates. **Initials:_________**

Patient or Guardian Signature: ________________________________ Date: _____________