ORTHOPEDIC ASSOCIATES, LLC

Acknowledgment of our Notice of Privacy Practices

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Orthopedic Associates, LLC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature of patient or Personal Representative

Consent for Communication

As a patient of Orthopedic Associates, LLC, I am giving my consent to release medical information including test results, diagnosis, surgery scheduling and treatment dates to the following individuals:

_____	_____	_____
Name	Relationship	Date
_____	_____	_____
Name	Relationship	Date
_____	_____	_____
Name	Relationship	Date

You may leave medical information on voice mail at these phone numbers:

Home: _____

Cell: _____

Our preferred method of communication for appointment reminders and scheduling changes is via text message. Please let our staff know if you do not wish to receive text messages from Orthopedic Associates.

Preferred method to reach you: □ Home Phone □ Cell Phone □ Text □ Other _____

Please make sure you have provided your cell phone number if cell phone or text messaging is your preferred contact method.

Additionally, I understand that this consent must be revoked in written form should I choose to do so.

_____ _____

Signature of Patient **Date**