WRMC ORTHOPAEDIC & SPORTS MEDICINE CLINIC

501 Virginia Drive, Suite C, Batesville, Arkansas 72501

Phone: (870) 793-2371 • Fax: (870) 793-7585

Consent to treat: I voluntarily consent to receive medical and healthcare services - these services may include diagnostic procedures, examinations, injections, blood work, and treatment.

Authorization to release insurance information: I hereby authorize release of medical information to give my insurance company or companies any insurance information they require concerning my case.

Authorization for Assignment of medical payments: I hereby authorize payment of any medical benefits to WRMC Orthopaedic and Sports Medicine Clinic.

Authorization to Access Rx History Information: I hereby authorize WRMC Orthopaedic and Sports Medicine Clinic to access my historical prescription drug information.

The undersigned herby authorizes WRMC Orthopaedic and Sports Medicine Clinic and the attending or consulting physician to photograph or permit other persons to photograph while under the care of the above medical organization, and agree that they may use or permit other persons to use the negative, prints, digital, and/or video prepared for such purposes and in such a manner as may be deemed necessary to provide medical care.
Use of photograph declined _____.

Authorization to Access Health Information Exchange: I hereby authorize WRMC Orthopaedic and Sports Medicine Clinic to send and receive my health information through state health information exchange. Yes☐ No ☐

☐Yes ☐Declined **I have received a copy of the notice of privacy practices written acknowledgement form.**

_____ _____ _____

Signature of Patient or Personal Representative | Relationship to Patient (parent, spouse, self) | Date

Printed Patient Name: _____

Please indicate by check mark your approval to leave the following information on voicemail, answering machine, email, or text.

O Appointment Date and Time Reminder

O DO NOT LEAVE MESSAGES OF ANY KIND

For Office Use Only

_____
Witness

_____
Patient Account Number

_____
Date Signed

The following people are allowed to: receive information regarding my care and/or have my permission to consent for the care of my child, disclosures of my health information that pertains to me as follows: history and physical examinations, consultation reports, operative reports, progress reports, billing records, discharge summaries, X-ray or MRI reports, X-ray or MRI disc, and medication prescriptions.

_____
Name and Relationship to Patient

_____
Name and Relationship to Patient

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Name and Relationship to Patient

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Name and Relationship to Patient