CORE

ORTHOPAEDICS & SPORTS MEDICINE

CLINTON M. RAY, M.D, & JEFFREY D. LAWLER, M.D.

HIPPA FORM

I, _____ Date of Birth _____ Chart # _____

(PRINT – Patient's Full Name)

AUTHORIZE: ALL PHYSICIANS AND STAFF OF CLINTON M. RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE

TO DISCUSS MY **MEDICAL TREATMENT AND CONDITION** WITH:
(Please check **ALL** that apply & **PRINT** Name(s))

____ Patient's Spouse: _____

____ Patient's Parent(s): _____

____Other (Specify Name & Relationship):_____

_____

_____

TO DISCUSS **FINANCIAL / ACCOUNT INFORMATION** WITH:
(Please check **ALL** that apply & **PRINT** Name(s))

____ Patient's Spouse: _____

____ Patient's Parent(s): _____

____Other (Specify Name & Relationship):_____

_____

_____

PURPOSE OF DISCLOSURE IS TO: **Allow Discussion of my Medical Treatment and Condition.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***ONE YEAR*** AFTER I CEASE MEDICAL TREATMENT WITH CLINTON M. RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE, LLC.

PURPOSE OF DISCLOSURE IS TO: **Allow Discussion of my pertinent Financial/Account Information.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***TWO YEARS*** FOLLOWING SATISFACTION OR PAYMENT OF ALL BALANCES OWED TO CLINTON M. RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE, LLC.

***TO ALLOW PICK UP of PRESCRIPTIONS (Rx's)**: *No one may be allowed to pick up prescriptions other than the patient or authorized person(s) below.
(Please check **ALL** that apply & **PRINT** Name(s))

____ Patient's Spouse: _____

____ Patient's Parent(s): _____

____Other (Specify Name & Relationship):_____

____Other (Specify Name & Relationship):_____

You may refuse to sign this authorization. You have the right to revoke this authorization at any time in WRITING. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to your insurance company when the law provides your insurer with the right to contest a claim under your policy. The information disclosed may be subject to re-disclosure by the recipient and no longer protected by law. Treatment, payment, enrollment in a health plan or eligibility for benefits is not based on the provision that you sign this authorization. You may request a copy of this authorization.

Signature of Patient or Legally Authorized Person _____ Date _____

If signed by other Legal Authorized Person, indicate Relationship to Patient _____

Credit Card Payment Authorization Program

To our Patients:

CORE Orthopaedics and Sports Medicine, LLC asks that you provide your insurance and credit card or debit card information at the time of service. After your insurance has processed the claim for your service, Clinton M. Ray, MD Orthopaedics and Sports Medicine, LLC will apply any remaining balance to your credit/debit card. Your card will only be charged if there is a balance after the claim is processed and all appeal rights exhausted. By using the payment authorization program, you will not receive a balance due invoice for any services.

- Clinton M. Ray, MD Orthopaedics and Sports Medicine, LLC secures all credit/debit card data.
- We will NOT place a hold on your credit/debit card.
- Your card will only be charged after your insurance has paid. This usually takes 30 to 45 days from date of service.
- Your credit/debit card information will be destroyed immediately after the insurance claims have been processed for final care and your services have been paid in full, unless you request that your information remains on file for children or spouse care.

Note: Co-Pays and Deductibles are still due at the time of the visit.

Please initial your preference and sign the option you choose.

____**Option 1:** I would like to choose Option 1 and have any remaining balance paid by the card below and confirmation given to me via

Phone#_____.

CREDIT CARD HOLDER INFORMATION

Please check credit card type:

____ Visa ____ Mastercard ____ Discover ____American Express

Credit Card #:_____ Expiration Date:_____/_____(mm/yy)

Exact Name as it appears on the credit card:_____

Billing Street # _____ Zip Code:_____CV2 Code on back_____

Signature of Cardholder:_____Date:_____

____**Option 2:** I would like to choose Option 2 and have any remaining balance billed to me. I understand that I will be charged interest/finance charge if balance is not paid in full by the 20th of the month in which statement is printed.

Signature:_____ Date:_____