Cascade Orthopedics
& Sports Medicine Center P.C.
1715 E 12th St., The Dalles, OR 97058

Acknowledgment and Consent

I understand that **Cascade Orthopedics, P.C.** will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Cascade Orthopedics, P.C. may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Cascade Orthopedics, P.C. Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Confidentiality Issues:

1. Do we have permission to leave message on "Telephone message machines" relating to your medical care with our office?
   [?] Yes [?] No

2. Do you want friends or family members that accompany you to appointments, to be invited into exam room (if space allows) [?] Yes [?] No

3. Cascade Orthopedics & Sports Medicine Center has my permission to discuss my health information with

   _____ . I understand that I may revoke this permission in writing at any time.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered and or received a copy of the Notice of Privacy Practices.

Signed: _____ Date:_____

Patient's Representative:_____ Date:_____
Description of Representative's Authority:_____
Print Patient Name: _____ Date of Birth:_____ Account #:_____