WEST IDAHO ORTHOPEDICS & SPORTS MEDICINE

ACKNOWLEDGEMENT OF RECEIPT

- NOTICE OF PRIVACY PRACTICES AND CONSENT FOR THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS
- FINANCIAL POLICY
- "GOOD FAITH" ESTIMATE NOTICE
- OWNERSHIP DISCLOSURE

Please read and initial each item:

_____I acknowledge that I have reviewed a copy of West Idaho Orthopedics **Notice of Privacy Practices**. This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights and responsibilities with respect to your protected health Information (PHI).

_____ I acknowledge that I have received a copy of West Idaho Orthopedics **Financial Policy**.

_____ I acknowledge that I have received a copy of the **Good Faith Estimate Notice** (for patients who don't have insurance or who are not using insurance).

_____ **Ownership Disclosure:** As a patient of West Idaho Orthopedics & Sports Medicine, your physician may order tests, images, and/or schedule procedures to be performed at local hospitals and/or imaging facilities. These include (but are not limited to) MRIs, x-rays, CT scans, laboratory tests, and surgical procedures.

Dr. John Q. Smith and Dr. Michael T. Daines have ownership interest in Treasure Valley Hospital where you may receive these services. Our providers have privileges at various hospitals which may include Idaho Surgery Center, St. Alphonsus Nampa, St. Luke's Nampa, St. Luke's Meridian, Treasure Valley Hospital, TVHSC, Ten Mile Surgery Center, and West Valley Medical Center. You have the right to have your services performed at any facility of your choosing.

This acknowledgment is to confirm that you have been informed of West Idaho Orthopedics & Sports Medicine's ownership interest and to inform you of your right to choose the facility where you would like to receive your services.

I acknowledge that I have reviewed the Notice of Privacy Practices. If a paper copy of the Notice of Privacy Practices is preferred, I will request a copy from the receptionist at the time of my appointment and review it before I sign below.

I have read and understand the West Idaho Orthopedics and Sports Medicine Financial Policy and agree to be bound by its terms. I also understand that such terms may be amended from time to time to West Idaho Orthopedics & Sports Medicine.

I acknowledge that I have reviewed a copy of the Good Faith Estimate Notice (for patients who don't have insurance or who are not using insurance). If a paper copy of the Good Faith Estimate Notice is preferred, I will request a copy from the receptionist at the time of my appointment and review it before I sign below.

Patient Name _____ Date of Birth _____

Signature _____ Date _____