

**ROY M. RUBIN, MD
PEDIATRIC AND GENERAL ORTHOPEDIC SURGEON**

Patient Consent for use and disclosure of protected health information

With my consent, the office of Roy M. Rubin, MD may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (HOP). Please refer to Roy M. Rubin, MD's Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Roy M. Rubin, MD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to: Privacy Officer, Roy M. Rubin, MD, 500 University Ave, Suite # 100 Sacramento, CA 95825

With my consent, the office of Roy M. Rubin, MD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out HOP, such as appointment reminders, insurance items or any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office of Roy M. Rubin, MD may mail to my home or other designated location any items that assist the practice in carrying out HOP, such as appointment reminders and patient statements. I have the right to request that the office of Roy M. Rubin, MD restrict how it uses or discloses my PHI to carry out HOP. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Roy M. Rubin, MD's use and disclosure of my protected health information to carry out treatment, payment and health operations.

_____ (Patient/Guardian initials)

Financial Agreement

"I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign directly to Dr. Roy M. Rubin, all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Print Patient Name

Signature of Patient or Legal Guardian

Print Name of Legal Guardian (if applicable)

Date