SOUTH SHORE ORTHOPEDICS

ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES: With this form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. South Shore Orthopedics (hereinafter referred to as the "Practice") reserves the right to change its Privacy Notice at any time but you may always obtain a copy upon request.

USE AND DISCLOSURE OF INFORMATION: As described in our Notice of Privacy Practices, we will use and disclose your individually identifiable health information for a variety of treatment, payment and health care operations purposes. Such disclosure of your information may be made via mail, telephone, fax, e-mail, and/ or Internet as may be necessary for the Practice to complete these purposes. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

APPLICABLE TO MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers for any information needed for this or a related medical claim.

ASSIGNMENT OF BENEFITS: In consideration for services and treatment rendered, I hereby assign, transfer and set over onto the Practice all health insurance, worker's compensation and automobile insurance, third party payment or any other benefits of any nature whatsoever now due to and payable to me including personal injury protection, medical payments, underinsured/uninsured benefits, and any other coverage which becomes available to me. I hereby direct my insurance company to make all payment I may be entitled to directly to the Practice.

RESTRICTIONS ON USES AND DISCLOSURES: As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions here:

Name (1)

Name (2)

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at 781-337- 5555 if I have further questions or any complaints. I hereby release Practice, its professionals, employees and agents, from all liability arising from the use and disclosure of my health information for treatment, payment and operations purposes. I understand that if I revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

Patient Name *

Patient/Guardian Signature *

Today's Date *

DISCLOSURE

If you are scheduled for a surgical procedure, we wanted to disclose to you that South Shore Orthopedics, LLC orthopedists collaborate with South Shore Hospital in an effort to improve quality and reduce costs called an integrated delivery network (IDN). Under this Agreement, your South Shore Orthopedics, LLC orthopedist may be rewarded for meeting specific goals for improving the quality and efficiency of care rendered at South Shore Hospital. You have the right to seek your orthopedic surgical care from other orthopedists that may not be a party to such a hospital agreement. Please do not hesitate to ask us any questions you may have about this disclosure.

Patient Name *

Today's Date *

Patient/Guardian Signature *

Use your mouse or finger to draw your signature above

[Clear]

DISCRIMINATION IS AGAINST THE LAW

South Shore Orthopedics, LLC (“SSO”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SSO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SSO provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters;

Written information in other formats (large print, audio, accessible electronic formats, other formats)

SSO provides free language services to people whose primary language is not English, such as Information written in other languages

If you need these services, contact the SSO Compliance Officer.

Name: David Kobasa, Practice Manager

Mailing Address: 2 Pond Park Road, Suite 102, Hingham, MA 02043 Telephone

number: 781-337-5555

Fax: 781-741-6252

Email: dkobasa@southshoreorthopedics.com

If you believe that SSO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the SSO Compliance Officer. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the SSO Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.