324 Roxbury Rd
Rockford, IL 61107
(815) 398-9491
(815) 381-7498 fax
www.rockfordortho.com

CONSENT TO TREATMENT AND NOTICE OF PRIVACY PRACTICES

Are your present symptoms or conditions related to or the result of an:
____auto accident
____work-related injury
____other personal injury **someone else might be legally liable for? ___ yes ___no**

Your Initials: ________

Attorney____ Telephone: ___________________

Address
____

CONSENT FOR MEDICAL TREATMENT

I present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include but not be limited to diagnostic procedures, x-rays, MRI's, injections, physical and occupational therapy, education and research and other treatments and procedures considered advisable in the diagnosis and treatment of my condition. I **realize** the practice of medicine and surgery is not an exact science. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examination at Rockford Orthopedic.

NOTICES OF PRIVACY PRACTICES

Rockford Orthopedic is committed to protecting your medical information. How we may use and disclose medical information and your rights regarding your medical information is published in our Notice of Health Information Practice brochure. I have been informed of this right and have also been asked if I would like a copy of Rockford Orthopedics Notice of Health Information Practices brochure.

I have been offered a copy of Rockford Orthopedic Associates Notice of Health Information Practices Brochure.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC DEVICES

Rockford Orthopedic meets the standards established by Medicare for all providers of durable medical equipment and prosthetic and orthotic devices. I have been offered a copy of Rockford Orthopedic Associates Supplier Standards Brochure, which describes the 26 Medicare Supplier Standards.

____
Print Name of patient and date of birth

____
Signature of patient/responsible party and date