National Scoliosis Center/3-D Body Imaging, LLC

Patient consent form

Use of this form is optional and not required under the HIPAA privacy rule

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **National Scoliosis Center/3-D Body Imaging, LLC (NSC/3D)** to use and disclose protected health information (PHI) about me to carry out **t**reatment, **p**ayment and health care **o**perations (TPO).

(The Notice of Privacy Practices provided by **NSC/3D** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **NSC/3D** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to National Scoliosis Center, 3023 Hamaker Court, Suite LL-50, Fairfax, Virginia 22031.

With this consent, **NSC/3D** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **NSC/3D** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **NSC/3D** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **NSC/3D** restrict how it uses or discloses my PHI to carry out TPO. 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 allow **NSC/3D** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **NSC/3D** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

National Scoliosis Center/3-D Body Imaging, LLC
3023 HAMAKER COURT, SUITE LL-50 | FAIRFAX VA, 22031 | (703) 849-8808 PHONE | (703) 942-6062 FAX

CONSENT OF REGISTRATION

Written Financial Policy

Thank you for choosing National Scoliosis Center/3-D Body Imaging, LLC (NSC/3D) to help meet your healthcare goals. Our primary mission is to deliver the best and most comprehensive care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

NSC/3D requires payment prior to the completion of your treatment/brace.

For patients with insurance we are happy to assist you to maximize your benefits and provide you with the documentation you need to receive any reimbursement for your treatment. Please understand that NSC/3D makes no guarantee of reimbursements from your insurance company, Flexible Spending or Health Savings Account.

A fee of $75.00 is charged for patients who miss or cancel their scheduled appointments without at least 24-hour notice.

NSC/3D charges $30 for all returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and deserve.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval