DONALD CLINTON MORRIS, JR., M.D., P.A.
Orthopaedic Surgery and Sports Medicine

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s orthopaedic needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment, procedures, and injections mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies certain risks.
4. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.

Patient: _____ Date: _____ Witness: _____

Parent / Responsible Party: _____ Relationship to patient: _____

Acknowledgement of Review of Notice of Privacy Practices (HIPPA)

I have received a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Name of Patient: _____ Date: _____

Signature of Patient: _____

Description of Personal Representative's Authority: _____

Names of Individuals that I give permission to have access to my medical records are as follows:

Individuals Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Authorization for Release of Health Information

I authorize D. Clint Morris, Jr. M.D. to release any and all information and records (including x- rays) about my medical history, or about services rendered or treatment provided to me, to health care service plans, insurance companies, self-insurers, or their representatives, when such information is needed to review, investigate, or evaluate and claim for benefits.
If my benefit coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization review or financial audit.

Name of Patient: _____ Date: _____

Signature of Patient, Parent, Guardian: _____