Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

Patient Name: _____

Date of Birth: _____

Consent for Medical Treatment

I hereby consent to examination, diagnosis and general medical care and treatment (including, but not limited to, physical exams, surgical procedures, administration of medications, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, physical therapy, and any other procedures/treatment that my doctor considers necessary.

I authorize the release of medical records information to insurance companies, third-party payers and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I authorize release of my medical record information as required or permitted by state or federal law including, but not limited to, for purposes of obtaining payment.

This office will bill your insurance company (including Medicare) for services provided. This office DOES NOT accept responsibility for collecting or failing to collect insurance claims, and you acknowledge that you are responsible for payment for any services provided, and that you will pay, any and all, charges due and owed to the practice (including any co-pays and/or deductibles).

The practice and the physicians providing services to you will initiate payment of your claims for benefits (and may also process appeals from decisions related to your claims and benefits). In order to do this, it is necessary for all responsible parties to give us certain rights and permissions:

1) I (as patient or as agent of the patient) hereby assign and transfer all rights of third-party payor benefits for services rendered to me to the practice and/or its physician(s) and authorize any insurance or third-party payments to be made directly to the practice and/or its physician(s).

2) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under the terms of any other insurance company, is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services and any other services to the physician(s) and/or organization(s) furnishing the services and authorize such physician(s) and/or organization(s) to submit a claim to Medicare or other insurance company for payment.

3) I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by my insurance company, and I will pay any and all charges due and owing OrthoAlliance, its subsidiaries, and/or its physician(s) in accordance with their regular rates, terms and policies.

Signature: _____ **Date**: _____

If person signing form is not the patient, please print your name and list relationship to patient:

Name _____ ***Relationship*** _____