



## Orthopedic & Sports Medicine Center

# Consent

**CONSENT TO TREAT:** I request and give consent to my physician to provide and perform such medical and surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. If the patient is a minor I certify that I am the legal guardian of the minor, \_\_\_\_\_, and I authorize the physician to perform the procedures required for medical evaluation and treatment. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me. Initial \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY BENEFITS:** I authorize my physician to release information from my medical record to my insurance carrier(s) or government agency for the processing of claims for medical benefits. I request that my insurance company (or companies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf. Initial \_\_\_\_\_

**MEDICARE CERTIFICATION:** I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize the physician who treats me to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers or to the Professional Standards Review Organization for processing of claims for medical benefits. I request that payment of authorized benefits be made directly to the physician treating me on my behalf. Initial \_\_\_\_\_

**FINANCIAL AGREEMENT:** I understand that all accounts are the responsibility of the patient and the patient's responsible party, guarantor, or parent(s). I acknowledge that the information provided by me is true and correct and that it has been furnished to this office with full knowledge that I am liable for all services rendered and that I am contractually bound to pay for said services. As a courtesy to me, my physician will assist me in obtaining insurance benefits by filing claims for services when I have assigned those benefits to my physician. I understand that it is my responsibility to respond promptly to any requests for information from my insurance carrier or my physician's office. I promise to pay collection costs, up to 50% of the balance owed to OSMC, and reasonable attorney fees incurred to effect collection of this account. Initial \_\_\_\_\_

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Signature of Patient/Parent/Guardian

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_