Advanced Orthopedic & Spine Care

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HEALTH CARE CONSENT

1. **To Treat.** I, for myself (or the patient named below) hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in a department of Advanced Orthopedic & Spine Care, hospital or for a course of outpatient treatment in the judgment of my physician(s), to be performed by Advanced Orthopedic & Spine Care physicians, nurses, and other health care providers/staff. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such involvement in my care.
2. **Responsibility for payment.** In consideration of services to be rendered by/at Advanced Orthopedic & Spine Care, the undersigned agrees, as patient or guarantor for patient, to pay Advanced Orthopedic & Spine Care for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to Advanced Orthopedic & Spine Care, financial contract arrangements are available upon request.
3. **Assignment of Benefits.** In consideration of services rendered at/by Advanced Orthopedic & Spine Care, I hereby assign and authorize direct payment to Advanced Orthopedic & Spine Care, any insurance, health plan, or third party payor benefits otherwise payable to me or on my behalf for these services.
4. **Medicare Payment & Assignment of Benefits.** (if applicable). I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me at Advanced Orthopedic & Spine Care and I assign such benefits to Advanced Orthopedic & Spine Care. I certify that the information given by me in. Applying for such benefits is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorized Social Security Administration to release information about my entitlement to benefits to Advanced Orthopedic & Spine Care providing services to me.
5. **Release of Medical Information for Payment.**
    A. General Release for Payment. I hereby authorize Advanced Orthopedic & Spine Care to release any and all pertinent information contained in my medical records, including HIV, mental health, and/or substance abuse to third party payors responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above
    B. By initialing in the space below, I do not consent to the release of medical information concerning HIV, mental health, substance abuse diagnoses or treatment if any, to third party payors and understand that I am personally responsible for payment for services HIV_____ Mental Health_____ Substance Abuse_____
6. **Duration & Revocation of Authorization for release of information for billing.** This authorization to release information related to payment expires upon satisfactory payment of the bill. This authorization (or the refusal under paragraph 58), may be revoked at any time by written notice to the Medical Records Department (with no effect on prior disclosures). If I revoke this authorization prior to satisfactory payment, I understand and accept that I am personally responsible for payment of all outstanding charges.
7. **Personal Belongings.** I assume full responsibility for all items of personal property, including but not limited to eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I hereby release Advanced Orthopedic & Spine Care of responsibility and liability for those valuables and items of personal property.
8. **Credit card payment authorization.** I hereby authorize Advanced Orthopedic & Spine Care to use my credit card for copays, co-insurance, non covered services, or other balances that are my financial responsibility if not paid within 45 days of service.
   Credit card type:_____#_____Expiration_____.
9. **Interest.** 1.5% interest will be accrued, per month, on balances due as described above after the aforementioned 45 days.

I have read and understand the above terms of treatment and confirm that I am the patient or authorized to sign on the patient's behalf.

Patient Name: _____ Date: _____

Patient Signature:_____Witness Signature: _____
(or patient/legal guardian, personal representative) If not signed by patient.