

CONSENT TO TREAT / RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "healthcare provider(s)" in this document refers to Integrity Orthopedics & Sports Medicine, its agents, employees, members of the medical staff, their agents and employees, and other healthcare practitioners who provide care to patients. I understand that, as part of my healthcare, this organization maintains health records that describe my health history, symptoms, examinations, test results, diagnoses, treatments, and any care plans, including future treatments. I understand that this information serves as:

1. The basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. A means by which a third-party payer can verify that billed services were provided
4. A tool for routine health care operations, including assessing the quality and reviewing the competency of our staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices, which provides more complete information on uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy or post any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed for payment, treatment, or healthcare operations, and that the organization is not required to agree to the requested restrictions. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already acted on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary during my care.

RELEASE OF INFORMATION

The healthcare provider involved in my care may release information about me that is necessary to substantiate insurance claims.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignments, I hereby authorize any insurance carrier with whom I have a policy to direct to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges not fully covered by the assigned insurance. If such amounts due to healthcare providers are not paid after reasonable notice, the account shall be deemed delinquent, and a service charge shall be added to the amount due. If I default on payment of the account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Integrity Orthopedics & Sports Medicine for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand that my signature requests payment, and I authorize the release of medical information necessary to process the claim. If other health insurance is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on the approved claim form or cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible amounts are based on the charge determination by the Medicare carrier.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Signature of person completing this form if not patient: _____

Relationship: _____ **Date:** _____