

Orthopedic Surgery Center & Sports Medicine

Patient Name: _____ DOB: _____ SSN: _____

Consent for Treatment/Assignment of Benefits

The undersigned, being the patient and/or guaranteeing party to the above named account hereby acknowledges and agrees to the following:

I. CONSENT FOR TREATMENT: I hereby consent to the evaluation and management services provided by Raul A. Marquez, MD, Orthopedic Surgery Center within this facility. Services may include diagnostic radiology. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

Signed: _____ Date: _____

II. RELEASE/OBTAIN INFORMATION: The undersigned understands that Raul A. Marquez, MD, Orthopedic Surgery Center may release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned understands that Raul A. Marquez, MD, Orthopedic Surgery Center may provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited to that which is deemed minimally necessary to execute referrals, etc.

III. STATEMENT OF FINANCIAL RESPONSIBILITY: In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor unconditionally guarantees payment in full to Raul A. Marquez, MD, Orthopedic Surgery Center. Orthopedic Surgery Center agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Raul A. Marquez, MD, Orthopedic Surgery Center understand that Orthopedic Surgery Center will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day state limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.

IV. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal Injury Protection or Medical Payment coverage, to pay directly to Raul A. Marquez, MD, Orthopedic Surgery Center proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage.

I acknowledge and accept the terms and conditions set forth in Sections III and IV of this policy statement:

Signed: _____ Date: _____ Relationship to Patient: _____

Responsibility for Non-Covered Services

I understand that the following treatment has been recommended by my physician and may not be covered by my insurance carrier. I agree to pay for these services at the rate noted below. Orthopedic Surgery Center will file a claim with my carrier and if coverage is available, reimbursement will be made directly to me.

Procedure: _____ Cost: _____

Procedure: _____ Cost: _____

Signed: _____ Date: _____