AUTHORIZATION/CONSENT FORM

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS:

I authorize and holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party that accepts assignment below. I request that the medical insurance program be made to me or to Orthopaedic Associates of Miami Lakes. 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 holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization. Please initial here _____ *

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION:

I authorize Orthopaedic Associates of Miami Lakes to release to your company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above-named doctor the amount due to me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service.

Please initial here _____ *

C. FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayment and co-insurance at the time of the visit. Please initial here _____ *

D. REFERRALS AND AUTHORIZATIONS:

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit may be rescheduled once proper authorization has been obtained. Please initial here _____ *

E. CONSENT TO TREAT:

I authorize Orthopaedic Associates of Miami Lakes to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the doctor(s) to perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate mediation and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made.

I understand that it is my responsibility to advise your office of any changes in the information contained in this form. Please initial here _____ *

F. MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Orthopaedic Associates of Miami Lakes, or any issuer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page. _____ *

G. TREATMENT OF MINORS:

I, as a parent/legal guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so. Please initial here _____ *

H. LIABILITY/ WAIVER AND RELEASE:

I know and agree that Orthopaedic Associates of Miami Lakes is not responsible for any loss or damage to personal valuables. I hereby release, discharge, and acquit Orthopaedic Associates of Miami Lakes, its agents, representatives, affiliates, employees, or of and from any and all liability claim, demand, damage, □use of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and /or medical services, including but not limited to ambulance, EMT, or Physician service. Please initial here _____*

I. INSURANCE:

As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and Orthopaedic Associates of Miami Lakes. You are responsible for full payment of your account, regardless of the status of your insurance claim. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. Please initial here _____ *

For patients without health insurance, payment is REQUIRED at the time of you visit. Please initial here if applicable_____*

J. NOTICE OF PRIVACY:

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. Please initial here _____ *

I, THE PATIENT/GUARANTOR/LEGAL GUARDIAN, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND INSURANCE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PHYSICIAN AND INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

*PATIENT/ GUARANTOR SIGNATURE x. _____ DATE: _____

*GUARDIAN SIGNATURE x_____ DATE: _____

If patient is under 18 years of age