Matthew S Davis, M.D.

Orthopedic Surgery & Sports Medicine

Authorization for Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment will be directed by a physician, Matthew S. Davis, M.D., and performed by employees of Davis Orthopedics. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Davis Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Davis Orthopedics is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation professionals, and/or coaches.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Davis Orthopedics for application on the patient's bill. The undersigned and/or patient agree to be responsible for obtaining referrals, charges not covered by the assignment, including deductibles and co-payments prescribed by law. ***Payment of co-pay and deductible is required at each office visit. No exceptions.***

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay all costs of collection, including reasonable attorney fees of one-third of the balance. ***As a courtesy to our patients, we will file insurance claims for the services rendered by this office. After the insurance has been processed, all balances are due within 30 days. Any balance not paid within the allotted time will accrue late penalties, including a $5.00 monthly billing fee. Payment plans with secure storage of credit cards are available and will avoid any late penalties and monthly billing fee.***

Miscellaneous Provisions: I understand that under no circumstances will Davis Orthopedics be liable for the property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

Patient's name:____ Social security number: ___________________________

Patient's signature: ____________________________________ Date of signing: _________________________________

or

*****If patient is a minor, age 18 or younger, the responsible person (parent or guardian) needs to complete the following. The adult that accompanies the minor patient is the guarantor (responsible party) for the account, not necessarily the insurance policy holder.***

Patient's name: ____ Date of birth: ______________________

*Person Responsible for account: ________________________________ Relationship to patient: ____________

*Responsible party's Social security number: _______________________ *Date of birth: ______________________

Responsible party's signature: ___________________________________ Date of signing: ____________________

Responsible party's address: ____

Phone: (205) 533-6644 Fax: (888)258-4852
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