CONSENT FORM

FINANCIAL RESPONSIBILITY

I realize my insurance is billed as a courtesy. **I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance, unless my insurer has an agreement with Westside Orthopaedic & Neurology Clinic, P.C. not to balance bill.**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign benefits from any and all accident, medical and third party insurances and authorize my carrier to make payment directly to Westside Orthopaedic & Neurology Clinic, P.C. I assign to Westside any and all rights to money owed to me in relation to evaluation and/or treatment performed by Westside staff and physicians up to the amount of the billed services.

RELEASE OF INFORMATION

I further authorize Westside Orthopaedic & Neurology to release to the insurance company or its agents or my attorney information necessary to process my claim/lawsuit. I authorize Westside to fax my records as necessary. I give permission for the physicians and staff involved in my care to discuss my case with the following individuals: Name: _____ Relationship

Name: _____ Relationship

CONSENT FOR TREATMENT

I hereby authorize the physicians and staff of Westside Orthopaedic & Neurology Clinic, P.C. to prescribe, administer, and perform such radiology examinations, laboratory tests, anesthesia, procedures and minor surgery as necessary or advisable in the diagnosis and treatment of my/patients condition. I understand that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee have been or will be made regarding the results of examinations or treatments in this clinic.

I have a "DNR "(do not resuscitate) order signed. Yes ____ No ____ This order is with (location)

THIS CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I AGREE TO THEM.

_____

Patient Patient's agent (if applicable)

_____

Witness Relationship to patient

_____

Date Date

CONSENT FORM

FINANCIAL RESPONSIBILITY

I realize my insurance is billed as a courtesy. **I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance, unless my insurer has an agreement with Westside Orthopaedics, P.C. not to balance bill.**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign benefits from any and all accident, medical and third party insurances and authorize my carrier to make payment directly to Westside Orthopaedics, P.C. I assign to Westside any and all rights to money owed to me in relation to evaluation and/or treatment performed by Westside staff and physicians up to the amount of the billed services.

RELEASE OF INFORMATION

I further authorize Westside Orthopaedics to release to the insurance company or its agents or my attorney information necessary to process my claim/lawsuit. I authorize Westside to fax my records as necessary. I give permission for the physicians and staff involved in my care to discuss my case with the following individuals:

Name:_____ Relationship

Name:_____ Relationship

CONSENT FOR TREATMENT

I hereby authorize the physicians and staff of Westside Orthopaedics, P.C. to prescribe, administer, and perform such radiology examinations, laboratory tests, anesthesia, procedures and minor surgery as necessary or advisable in the diagnosis and treatment of my/patients condition. I understand that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee have been or will be made regarding the results of examinations or treatments in this clinic. I further authorize Westside to email reminders to me.

My email address
I have a "DNR "(do not resuscitate) order signed. Yes ____ No

This order is located:
THIS CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I AGREE TO TERMS THEREIN.

_____

Patient Patient's agent (relationship) Witness Date

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW AND OFFERED A COPY OF WESTSIDE ORTHOPAEDICS "NOTICE OF PRIVACY PRACTICES"

_____

Patient Patient's agent (relationship) Witness
Date