OSMC REHAB&THERAPY

Patient Consent

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Orthopedic & Sports Medicine Center (hereinafter referred to as "OSMC") to furnish medical care, diagnostic testing, and treatment to _____, which is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition. (Print Patient Name)

BENEFIT OF ASSIGNMENT

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third-party payers to OSMC. A photocopy of this assignment is to be considered as valid as the original.

ATTENDANCE, CANCELLATION, AND NO-SHOW POLICY

I understand attendance is expected and vital to achieving wellness goals. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel / no show charge of $35.

VIDEO MONITORING / PHOTOGRAPHS / VIDEO RECORDING

I understand that certain aspects of my treatment at OSMC may be monitored by a security video system. Furthermore, I agree that I will not photograph and/or videotape any OSMC employee, facility, or treatment procedure without prior written consent of the facility manager.

PHOTO & FILMING RELEASE AUTHORIZATION

(Initials) I, the undersigned, give my permission to be photographed and/or filmed at OSMC I also give my permission for OSMC to use such photos and in all forms of media, for any and all promotional purposes including advertising, display, audiovisuals, exhibition and editorial use

FINANCIAL POLICY STATEMENT

Please note: OSMC is sometimes referred to as "we". The undersigned is sometimes referred to as "you", "your", "my" and/or "I".

As a courtesy to you, OSMC will attempt to verify coverage with your insurance company. OSMC does not guarantee the accuracy of the information provided by your insurance company, nor do we guarantee your coverage. You are responsible for the entire balance of your bill. OSMC shall bill your insurance carrier solely as a courtesy to you. OSMC requires that arrangements for payment of your estimated share be made at the time of your initial appointment. If your carrier does not remit payment within 60 days, the balance will be due in full. After 60 days, any balance unpaid shall begin to accrue monthly interest at 1.5%. In the event that your insurance company requests a refund on any payment for whatever reason, you will be responsible for the amount of money refunded to your insurance company.

The above does not apply for patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and such claim is subsequently denied at any time in the future, you may be held responsible for the total amount of charges accrued during your treatment. In the event such Worker's Compensation claim is denied, and if OSMC is a participating provider with your insurance plan, we shall, as a courtesy, bill your entire balance to your group health insurance. Any residual unpaid balances will be your responsibility.

If any payment from any source is made directly to you for any services rendered by OSMC, you recognize an obligation to promptly remit those payments to OSMC. By signing this consent, you authorize the direct payment to OSMC of any sum you now or hereafter owe, by your attorney, out of proceeds of any settlement of your case.

Private Insurance and Medicare Patients: You understand and agree that any supply that is not covered or paid for by your insurance company may be your responsibility.

You acknowledge and agree that our legal fees, collection fees and contingent fees for which you will be responsible may be measured as a percentage of all other amounts you owe OSMC or amounts ultimately collected from you. The foregoing sentence does not apply where expressly prohibited by law and where prohibited by law, has no impact on the remainder of this agreement / authorization.

I understand and agree that if I fail to make any payments on the balance due for which I am responsible, all costs of collecting monies owed including 1.5% interest monthly on any balances over 60 days, legal fees (whether or not we have to employ the services of an attorney), court costs, third-party collection fees and any contingent fees which OSMC is obligated to pay in effort to collect on the account shall be my responsibility.

I authorize OSMC to file appeals with my insurance company or initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand the above information. I understand my responsibility for the payment of my account.

Patient / Guardian / Responsible Party Printed Name: _____

Patient / Guardian / Responsible Party Signature: _____ Date: _____

Center Representative / Witness: _____ Date: _____