ALLIANCE
SPORTS MEDICINE

PATIENT CONSENT & AUTHORIZATION

ALL Patients Read and Initial 1, 2, 3, and 4

1._____Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

2._____Release of Information: By my signature on this form, I am granting consent to doctors, therapists and staff of Alliance Sports Medicine to use and disclose protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant you request; however, if we do decide to grant your request, we are bound to disclose your protected health information in reliance on your request. I acknowledge that I have received a copy of the Notice of Health Information Privacy Practices.

3._____Assignment of Benefits: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physicians' regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

4._____Resolution of Disputes: In the rare circumstance that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

IF appropriate, initial 5, 6, or 7

5._____Medicare and Medicaid Consent to Release Information: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare or Medicaid claim.

6._____(Female Patients ONLY) Verification of Non-Pregnancy: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.
The date of last menstrual period _____(start/end).

7._____Permission to Evaluate and Treat a Minor Child/ Dependant Adult: I authorize doctors, therapists and staff of Alliance Sports Medicine to evaluate and treat_____.

Print Patient's Name:_____
Patient's Signature: _____Date:_____
Parent/Guardian Permission to treat: _____
Relationship:_____ Date:_____
Witness:_____ Date:_____

Patient has received a copy of the Notice of Privacy Practices.