



PATIENT AUTHORIZATION AND SIGNATURE PAGE

BILLING AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I hereby assign to and authorize payment directly to Carolina Orthopedic and Sports Medicine, Inc. for all benefits payable under the terms of any insurance policy listed. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care.
2. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its Intermediaries or Carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance and any non-covered services as determined by Medicare.

AUTHORIZATION FOR TREATMENT

1. I hereby consent to the rendering of medical care, which may include routine diagnostic procedures, laboratory testing, medical and/or surgical procedures and physical and/or occupational therapy performed by authorized physicians and/or staff members of Carolina Orthopedic and Sports Medicine, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. We are committed to protecting your privacy and ensuring that your Protected Health Information is used and disclosed appropriately. The Notice of Privacy Practices identifies all potential uses and disclosures of your Protected Health Information by our practice and outlines your rights with regard to the use and disclosure of that information.
2. I acknowledge understanding of and I have received a copy of the Notice of Privacy Practices for Carolina Orthopedic and Sports Medicine, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF THE PATIENT FINANCIAL AGREEMENT

1. I acknowledge understanding of and I have received a copy of the Patient Financial Agreement.
2. I agree to abide by the terms of the Patient Financial Agreement.

X _____

PRINT NAME

X _____

PATIENT/PARENT or GUARDIAN SIGNATURE

DATE: