ADVANCED
ORTHOPEDICS AND SPORTS MEDICINE

Patient Name: _____

Date of Birth: _____

MRN: _____

Date of Service: _____

## Consent for Outpatient Services

**Consent for Treatment:** I voluntarily consent to care provided by Advanced Orthopedics and Sports Medicine and its employees. I understand that I am consenting to care, which may include, but is not limited to, x-rays, diagnostic procedures, medical and procedural treatments (including emergency medical treatment), and other medical services as deemed necessary in the treating provider's judgement. This may include taking of photographs and videos that may be useful in diagnosing, documenting, or treating my condition or that may be useful for medical education or quality improvement purposes. I am aware the practice of medicine is not an exact science, and I understand no guarantees have bene made to me regarding my care. As a patient of Advanced Orthopedics and Sports Medicine, I understand that individuals being trained in healthcare may participate in my care. I also understand that healthcare vendors may be present during my care. I consent to their presence and assistance under general supervision of my care team.

**Medication History:** I give Advanced Orthopedics and Sports Medicine permission to collect information my pharmacy and healthcare plan may have disclosed. This includes information about filled prescriptions at any pharmacy or covered by any health insurance plan. This may not include over-the-counter medications, herbal supplements, herbal remedies, medications not reported by the pharmacy or my healthcare plan, or medications I paid for out of pocket. The medication history from my pharmacy and healthcare may not be completely accurate so it is very important for me to point out any errors or omissions in my medication history.

**Personal Property:** I understand that Advanced Orthopedics and Sports Medicine is not responsible for loss or damage to my personal property brought to the facility.

**Financial Consent:** I agree to be responsible for payment of all Advanced Orthopedics and Sports Medicine charges and for all professional fees, regardless of whether they are covered by insurance. I will submit applications to federal, state and county programs when appropriate. I understand Advanced Orthopedics and Sports Medicine will bill me, my family, and/or other responsible parties for services provided. I understand Advanced Orthopedics and Sports Medicine will inform me of my outstanding balances and may accrue interest on such balances as authorized by law. If balances remain unpaid, I understand Advanced Orthopedics and Sports Medicine will initiate collection activities, report delinquent accounts to credit bureaus, and may also initiate legal action to collect outstanding balances.

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**Assignment of Insurance Payment:** I hereby authorize my insurer to pay Advanced Orthopedics and Sports Medicine directly for claims and reimbursements. This assignment is effective only if allowed by my insurance plan and accepted by Advanced Orthopedics and Sports Medicine. I understand claims may be made upon any health insurance policy or policies providing coverage for care and treatment and for provider services rendered.

**Automated Messages:** To the extent consent is required by the Telephone Consumer Protection Act or other applicable law, I hereby authorize Advanced Orthopedics and Sports Medicine and its designees to deliver messages to me through the use of an automatic telephone dialing system or an artificial or prerecorded voice at any telephone number I have provided to Advanced Orthopedics and Sports Medicine. I am not required to agree to receive such automated calls, and my agreement is not a condition to receiving items or services from Advanced Orthopedics and Sports Medicine. Advanced Orthopedics and Sports Medicine does not waive and expressly reserves the right to contact me by any means for any purpose as otherwise permitted by law.

_____ _____

**Patient/Patient Representative Signature** **Date/Time**

_____ _____

**Witness Signature** **Date/Time**

By signing as a witness for Advanced Orthopedics and Sports Medicine, I attest that the patient/patient's representative has been provided with the above information and given consent to receive outpatient services.