MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC.

PLEASE READ THE FOLLOWING:

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF HOSPITILIZATION OR SURGERY IS INDICATED, WE WILL FILE YOUR CLAIM CIRECTLY TO THE INSURANCE COMPANY. PLEASE REMEMBER THAT MOST INSURANCE COMPANIES DO NOT PAY THE FULL AMOUNT, AND THEREFORE YOU ARE RESPONSIBLE FOR THE BALANCE. IF THERE IS A PROBLEM PAYING THE BALANCE IN FULL, PLEASE LET US KNOW AND WE WILL BE HAPPY TO WORK WITH YOU.

FINANCIAL RESPONSIBILITY
I UNDERSTAND IF I HAVE SECURED THE APPROPRIATE REFERRALS AND AUTHORIZATIONS FOLLOWED THE TERMS OF MY HEALTH PLAN BENEFITS, THERE MAY BE A DECREASE IN MY COVERAGE OR NO COVERAGE AT ALL FOR SOME OR ALL OF THE SERVICES WHICH I AM ABOUT TO RECEIVE, AND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR THE SERVICES NOT COVERED, INCLUDING CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES. IF I HAVE NO INSURANCE, I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED.

PATIENT'S OR GUARDIAN'S
SIGNATURE_____

INSURANCE AUTHORIZATION AND RELEASE
I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS, INCLUDING MEDICARE, AND ANY OTHER GOVERNMENT SPONSORED PROGRAM, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLANS BE MADE TO MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC. FOR ANY SERVICES FURNISED BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THOSE PERSONS OR COMPANIES PRESENTING LEGITIMITE REQUEST FOR SUCH INFORMATION NEEDEDTO DETERMINE THESE BENEFITS OR THE BENEFIT PAYABLE FOR RELATED SERVICES. I AUTHORIZE MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC. TO ACT AS MY AGENT TO HELP ME OBTAIN ANY REQUIRED PRE-CERTIFICATION AS WELL AS ACTING AS MY AGENT TO HELP ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE MY INSURANCE COMPANIES TO GIVE MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC. ANY INFORMATION TO REQUIRE TO FULLFILL THIS FUNCTION. THIS WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT AND RELEASE IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT'S
SIGNATURE_____

MEDICAL RECORDS RELEASE
I HEREBY AUTHORIZE MEDICAL CENTER FOR BONE AND JOINT DISORDERS INC. TO RELEASE ANY INFORMATION IN MY CHART TO ANY PRACTIONER, DOCTOR, HOSPITAL, OR MEDICAL INSTITUTION TO WHOM I MAY BE REFERRED TO ASSIST IN MY CARE. ADDITIONALLY, I AUTHORIZE ANY REQUEST FOR MEDICAL INFORMATION FROM ANY MEDICAL PRACTIONER, DOCTOR, HOSPITAL, OR MEDICAL INSTITUTION TO ASSIST IN MY CARE.

PATIENT'S
SIGNATURE_____

OFFICE EXAMINATION
I CONSENT TO HAVE AN EXAMINATION BY DR. I. SCOTT GOLDMAN, M.D. AND OR ASSOCIATES.

PATIENT'S
SIGNATURE_____

DISCLOSURE
THE MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC. IS AN INTEGRATED ORTHOPAEDIC MEDICAL PRACTICE THAT EMPLOYS PHYSICAL THERAPISTS TO TREAT ITS PATIENTS. DR. I. SCOTT GOLDMAN OWNS BOTH MEDICAL CENTER FOR BONE AND JOINT DISORDERS, INC. AND PREMIER PHYSICAL THERAPY. PREMIER PHYSICAL THERAPY WAS DEVELOPED TO PROVIDE QUALITY OF CARE TO ALL OF OUR PATIENTS IN ONE CONVENIENT LOCATION, HOWEVER IF YOU CHOOSE TO GO TO ANOTHER FACILITY PLEASE NOTIFTY THE DOCTOR AS THEY WILL GLADLY REFER YOU TO ANOTHER FACILITY.