Medical Consent Form

Patient Name: ____ Date: _________

AUTHORIZATION TO RELEASE INFORMATION

I authorize to furnish any consulting physician, hospital, physical therapy facility, MRI facility, and/or medical supplies facility and their representatives, any information or copies of all medical records, consultations, and prescriptions relating to my illness or injury. I authorize All American Orthopedic and/or staff to furnish medical records relating to my illness or injury to the contracted billing company, Medical Insurance Processors, to file appropriate medical information to my insurance company for reimbursement. A copy of this authorization shall be in effect and valid until rescinded in writing **_______ {initial)**

AUTHORIZATION OF INSURANCE BENEFIT PAYMENTS

I authorize direct payment of medical benefits through my insurance carrier of worker's compensation carrier for services rendered. I understand that I will be billed and held responsible for any balance insurance does not pay. I understand that office deductibles, percentages, and/or co-pays are due and payable at the time of my office visit. I understand that if my condition requires surgical intervention, my insurance company will be contacted for eligibility and precertification. If the representative for All American Orthopedic and Sports Medicine Institute is advised by my insurance company that I will be responsible for a percentage of the fee, I understand that I will be asked to pay this portion prior to my surgery. **_______ (initial)**

AUTHORIZATION OF PAYMENT RESPONSIBILITY

I understand that I am financially responsible for all services rendered by any Physician, staff member or any other associate while under the care of All American Orthopedic or any Physician associated with the practice. **_____ (initial)**

CONSENT FOR MEDICAL TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment do hereby voluntarily consent to such procedures and care under the specific instructions of All American Orthopedic, and/or their representatives. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by All American Orthopedic and Sports Medicine Institute. I acknowledge that X-ray films will be taken for my condition at the time of my visit and these will be viewed by the All American Orthopedic and Sports Medicine Institute physician at his workstation. Upon completion of my visit with All American Orthopedic and Sports Medicine Institute, a verbal dictation will be made by the All American Orthopedic and Sports Medicine Institute physician at his workstation. **_____ (initial)**

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS AND/OR SCHOOL PERSONNEL

I authorize All American Orthopedic and Sports Medicine Institute and/or staff to relay medical information to: **spouse____ stepparents _____ family member ____ school staff _____ (coaches, physical trainers, school administration personnel)**

CONSENT TO LEAVE MESSAGES

I authorize All American Orthopedic and Sports Medicine Institute, and/or staff, to leave necessary messages and appointment reminders at my home or place of employment. **______ (initial)** I authorize All American Orthopedic and Sports Medicine Institute and/or staff to use MRI's or X-rays for research and/or teaching purposes only. **_____ {initial)**

MEDICAL TRAINING

All American Orthopedic and Sports Medicine Institute is a teaching facility for medical professionals. At times we may have interns, residents, fellows, or medical/chiropractic students and allied arts students, rotating through our offices. These students follow the same rules of confidentiality and professionalism as do all of our medical professionals. You are free to decline having a student or medical trainee in your office consultation by informing your nurse or physician.