

Consent & Release

To the best of my knowledge, the information on the opposite side of this form is true and accurate.

I understand that Midwest Bone & Joint Center, PC, utilizes telemedicine technology.

I understand that Midwest Bone & Joint Center, PC, will pre-certify all surgeries and MRI services for all insurance/Medicare plans (including Worker's Compensation) that require it. It is my responsibility to know the benefits of my insurance.

I hereby authorize payment directly to Midwest Bone & Joint Center, PC, of all insurance/Medicare coverage for surgery, and/or office charges, and I authorize them to release any information necessary to process insurance benefits on my behalf. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage.

I understand that provider and office fees are due and payable when services are rendered. I understand that I am fully responsible for all charges and any balance due after payment by insurance, and that insurance coverage does not necessarily guarantee payment of charges. I also understand that any account balance over 90 days will be assessed a finance charge, and/or billing charges.

A copy of your insurance card(s) and drivers license is required.

HIPAA Authorization

I have been informed by Midwest Bone & Joint Center, PC, that the "Notice of Privacy Practices" is available in the waiting room for review. I understand that I have the right to ask questions in order to seek clarification.

Release of Information

I authorize Midwest Bone & Joint Center, PC, to discuss my Protected Health Information with the following individuals.

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

I authorize Midwest Bone & Joint Center, PC, to:

Leave a message on home answering machine Yes No

Leave a message at my place of employment Yes No

I agree to the terms above, and authorize treatment by the provider(s) in this office.

Patient's signature _____ Date _____

Print patient's name _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chris Main, D.O. or Nola F. Moore, NP (Midwest Bone & Joint Center, PC) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance: is indicated in Item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's signature _____ Date _____