RELEASE-AUTHORIZATION-ASSIGNMENT OF BENEFITS

Consent to Treatment
I, the undersigned patient, agent for the patient, or legal guardian, consent to the procedures which may be performed on me during my visits to this office. I authorize **West Coast Center for Orthopedic Surgery and Sports Medicine** and its physicians, fellows, visiting residents, and/or technicians to perform on me any and all required treatments and all required treatments and/or procedures, including but not limited to emergency treatment and services, laboratory procedures, minor surgeries, physical examinations, x-rays, injections, EMG/NCV studies or physical therapy sessions. I agree that if I discontinue medical care at this office contrary to the opinion or decision of this physician, I will hereby relieve this office, physicians, and associates of all responsibilities for my health.

Release of Information
I, the undersigned patient, agent for the patient, or legal guardian, agree that to the extent necessary to determine responsibility for the payment and to obtain reimbursement, **West Coast Center for Orthopedic Surgery and Sports Medicine** and associates may disclose and/or release a portion or all of the patient's record including his/her medical record, to any person or entity which is or may be responsible for all or any portion of the office and/or physicians charges including but not limited to insurance companies, health care service plans, workers compensation carriers, personal injury attorneys, medical or utilization review organization designated by any of the foregoing or to any other person or entity as necessary in connection to such payment or reimbursement.

Assignment of Benefits
This medical office will prepare any and all necessary reports and itemization to assist in making collections of claims from insurance companies and will credit any such collection to the patients' account. However, we cannot render services under the assumption that our charges will be paid by insurance companies. Patients who carry any form of medical or surgical insurance coverage should know that they are personally responsible for payment of services rendered. I, the undersigned patient, agent for the patient, or legal guardian, agree that in return of the services to be rendered for the patient, I authorize direct payment to the physician and/or medical group of any insurance or health plan benefits and/or claims otherwise payable to or on behalf of the patient for professional services rendered during this office visit including emergency services if rendered. In the absence of such payment, this physician and/or medical group is further assigned all necessary rights to collect such benefits and/or payments. I, the undersigned patient, agent for the patient, or legal guardian, authorize **West Coast Center for Orthopedic Surgery and Sports Medicine**, or billing department, to represent me, the patient, in any appeal process or claim denial appeal in order to collect payment from the appropriate insurance company and/or responsible party. It is agreed that payment so such physicians pursuant to this authorization by an insurance company and/or health plan shall discharge said insurance company and/or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. The undersigned authorizes this physician and/or medical group to contact patient's employer and/or insurance carrier for the purpose of determining the existence and the extent of the insurance benefits, and to obtain and collect payment for services rendered.

Authorization for Release of Medical Records
I, the undersigned patient, agency for the patient, or legal guardian, hereby grant permission to and authorize any physician, medical practitioner, hospital, pharmacy, clinic, or other medical or medically-related facility or provider of medical or dental services or supplies, any employer, insurance or reinsurance companies, benefits plan administrator, educational institutions, or any federal, state or local government agencies, including social security administration, veteran administration, and/or entities to release my complete medical records in their possession to **West Coast Center for Orthopedic Surgery and Sports Medicine** and/or physicians. A photocopy or facsimile of this authorization shall be valid and effective as the original.

Medicare Patients Release of Information
I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made directly to this physician and/or medical group and I understand that I am responsible for the remaining balance not covered by other insurance.

Notice of Privacy Practice – HIPAA Compliance
This facility is HIPAA compliant. The patient's privacy is protected including medical and personal information. As required by law, we will use and disclose our patients health information in a limited way according to the requirements by all applicable laws, I, the undersigned patient, agent for patient, or legal guardian, have been informed of my privacy rights.

Patient's Name________________________ **Signature**___________________________

Relationship to Patient______________________ **Date**___________________________

WEST COAST CENTER FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE