The Shoulder Center, PC

Pre-certification & Financial Responsibility: I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that pre-certification may be the responsibility of the patient or financially responsible party. I also understand that I am financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

I have read and understand the above consent _____ (Initials)

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to The Shoulder Center, PC, all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to The Shoulder Center, PC. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and The Shoulder Center, PC.

I have read and understand the above assignment _____ (Initials)

Consent to Release Claims Information: I hereby consent for The Shoulder Center,PC, their employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of treatment, health care operations and evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize The Shoulder Center, PC, its employees and agents to act on my behalf in completing claims. I (or the patient) may revoke this consent in writing at any time and all future disclosures will then cease. I (or the patient) may restrict the uses of information with written notice and if agreed to by The Shoulder Center, PC, the additional limitations are binding.

I have read and understand the above release _____ (Initials)

I HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, AND ASSIGNMENTS INCLUDING THE FINANCIAL POLICY AND PATIENT PRIVACY POLICY AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

_____

Patient's Printed Name

_____ _____

Signature of Patient Date Witness

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is described as follows:

_____

Signature of Authorized Representative Date

_____ _____

Relationship to Patient Witness