CONSENT/AUTHORIZATION for TREATMENT

1) **I consent to services, treatment and diagnostic procedures, including but not limited to medications, x-rays and lab tests which may be ordered by my provider at Westover Hills Orthopaedics.**
2) **I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICES unless other arrangements are made with the financial department. By signing this consent, I assign all rights, title and interest and authorize direct payments to Westover Hills Orthopaedics of any insurance benefits or benefits under the Social Security Act for the services. Westover Hills Orthopaedics will assist in billing my insurance company but I am financially responsible for the charges not collected by this assignment. I authorize Westover Hills Orthopaedics to bill my insurance or third-party payor and receive payment from them directly.**
3) **I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement Westover Hills Orthopaedics may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore, Westover Hills Orthopaedics may disclose my records to other treating providers, health care providers, audit committees for quality improvement, and applicable state and federal agencies.**
4) **My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy of a faxed copy of this authorization shall be deemed as valid as the original.**

Signed: _____ Date: _____

(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____