Napa Valley Orthopaedic Medical Group, Inc.

CONSENT FOR TREATMENT

Adult

I hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

_____Initial

OR
Complete for a Minor

I certify that I am a legal guardian for _____, a minor, and I do hereby give Napa Valley Orthopaedic Medical Group, Inc., its physicians, and its medical staff my consent for any necessary medical evaluation and treatment.

_____Initial

INSURANCE ASSIGNMENT

I give permission to Napa Valley Orthopaedic Medical Group, Inc. to bill my insurance carrier for services rendered. I understand that this is a service provided by Napa Valley Orthopaedic Medical Group, Inc. I request that payment of authorized Medicare or other insurance company benefits be made directly to Napa Valley Orthopaedic Medical Group, Inc., otherwise payable to me, for any services furnished to me by Napa Valley Orthopaedic Medical Group, Inc. Regulations pertaining to Medicare assignment of benefits apply.

I permit a copy of this authorization to be used in place of the original. I understand that I must inform my physician if I know that a party other than Medicare is responsible for paying for my treatment.

I understand that I am responsible for my medical bills unless I have verified coverage under an active Worker's Compensation claim. I hereby guarantee payment of all physician/provider charges and understand that any amount not paid by insurance within 60 days of service becomes my personal responsibility unless my injury is covered under and active Worker's Compensation claim. Examples of this would include but not limited to any coinsurance, deductibles, and copayments.

_____Initial

INFORMATION RELEASE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance, information needed for this or a related Medicare or other insurance company claim. I understand that my signature requests that payment be made and authorizes release of any medical or other information necessary to pay the claim.

_____Initial

PAYMENT POLICY

It has been explained to me that if I am paying for medical treatment, payment of all charges is to be made in full at the time of services unless previous arrangements have been made, and I agree to pay all the charges. A full financial policy follows.

If there is a co-payment for the medical services, I understand that it is due at the time of services, and I agree to make this payment.

_____Initial

I have carefully read and agree to the above information.

Signature:_____ Date:_____

Name: _____