CONSENT FOR TREATMENT / ASSIGNMENT FOR BENEFITS

Patient Name _____ SSN _____ Acct. #: _____

CONSENT FOR TREATMENT / SERVICES

I hereby voluntarily consent for treatment provided by Lancaster Orthopaedics & Sports Medicine. I permit the Facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s).

ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

NOTICE OF PRIVACY PRACTICES

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

Consent to Release Information to Coach or Athletic Trainer

I understand that healthcare information may be disclosed to the school coach or athletic trainer in order to provide my child with the best comprehensive care. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

_____	_____	_____
Name of School Attending	Parent or Legal Guardian's Signature (Students 18 years of age or older may sign consent)	Date

The undersigned certifies s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

★ _____ **Patient's Signature or Legal Representative**	_____ **Date**
_____ **Relationship to Patient**	_____ **Time**
_____ **Witness of Signature**	_____ **Interpreter, if utilized**
	_____ **If Telephone Consent, Second Witness' Signature**