9159 W Flamingo Road • Las Vegas, NV • 89147 • 702-485-5885

<u>Consent for Medical Treatment:</u> I consent to Ortho Las Vegas performing medical and/or diagnostic procedures on me (or, if I am signing as an authorized person, the patient). I understand that some of the practitioners may be employees of Ortho Las Vegas and others may be independent contractors of Ortho Las Vegas. I understand that I will be informed of the treatment and diagnostic procedures considered necessary and/or advisable. I understand that no guarantee or assurance has been made as to the results that may be obtained from treatment.

<u>Information Privacy:</u> I have received Ortho Las Vegas's Notice of Privacy Practices, which Ortho Las Vegas has prepared to help its patients better understand the policies and their rights with respect to their personal health information. I understand that the terms of the notice may change with time and that Ortho Las Vegas will always post the current notice at its facilities and on its website, as well as have copies available for distribution.

<u>Release of Information:</u> I consent to allow Ortho Las Vegas to disclose all or part of my information regarding medical condition, treatment, and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation practitioners, nurses, orthopedic technicians, and/or coaches. I also consent to Ortho Las Vegas utilizing medical information obtained during the course of the treatment in medical research and education programs, provided my (or the patient's) name and likeness are not revealed and my privacy is protected.

<u>Assignment of Insurance Benefits:</u> I consent to billing by Ortho Las Vegas and request that the payment of authorized Medicare, Medicaid and/or other third-party insurance benefits, including supplemental, co-insurance and Medigap policies is made on my behalf directly to Ortho Las Vegas for products sold to me by Ortho Las Vegas and identified above. I agree to provide all documents and information necessary to Ortho Las Vegas to obtain direct payment from Medicare, Medicaid or other third-party payers and hereby authorize the release of any medical information to determine and obtain insurance benefits for products and services provided to me by Ortho Las Vegas. I agree to transfer immediately to Ortho Las Vegas any payments made directly to me for products and/or services provided by Ortho Las Vegas. I authorize Ortho Las Vegas to appeal denied insurance authorizations and/or benefits.

<u>Financial Responsibility:</u> I understand and agree that I am financially responsible to Ortho Las Vegas for payment of applicable deductibles and coinsurance and any other amounts that are not covered by my insurance, including being subject to Ortho Las Vegas's Credit Card on File Policy. I agree to assign payment for the unpaid charges from services provided by a specialist and by physicians for whom Ortho Las Vegas is authorized to bill. Should the account be referred to an attorney for collection, I agree to pay all costs of collections, including, to the full extent permitted under applicable law, reasonable attorney fees. All delinquent balances shall bear interest at the legal rate.

<u>Credit Card on File Policy and Automated Call Authorization:</u>

- I have received a copy of, and I understand and agree to all of the terms of, Ortho Las Vegas's Credit Card on File Policy.
- I authorize Ortho Las Vegas to keep my signature and valid credit card number securely on file.
- I agree to allow Ortho Las Vegas or its agent to automatically charge my credit card for any outstanding balance, including but not limited to insurance denials for any reason, deductibles, co-insurances, partially paid claims, and any other charge my insurance carrier (or the insurance carrier that covers any individual whose payment of services I have accepted responsibility for, including as applicable my spouse, children, or other related party) has not or I have not already paid.
- I agree to allow Ortho Las Vegas or its agent to charge my credit card if my insurance company delays or denies payment of any services or products Ortho Las Vegas provides.
- I agree to promptly give Ortho Las Vegas information for a new, valid credit if the credit card I have on file is expired, cancelled, or otherwise cannot be charged.
- I agree to give Ortho Las Vegas correct contact information and to promptly update my contact information if any changes.
- I agree to allow Ortho Las Vegas, or a third party acting on behalf of Ortho Las Vegas, to contact me through any of the following means: by mail, by email, by telephone call (including calls made by an automatic telephone dialing system, and calls that may contain a pre-recorded message), and by text message.
- I understand and agree that Ortho Las Vegas will use the contact information I provide and that is it my responsibility to control who has access to my mail, email, and telephone.
- I understand and agree that this authorization, including all the terms above, will continue to valid unless and until I cancel this authorization by providing Ortho Las Vegas written notice that I am cancelling this authorization.

<u>Medicare Authorization:</u> I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

<u>Miscellaneous:</u> I understand that under no circumstances will Ortho Las Vegas be liable for property of patients.

I HEREBY CERTIFY THAT I HAVE READ, I UNDERSTAND, AND I AGREE WITH THE FOREGOING, THAT I AM EITHER THE PATIENT OR I AM AUTHORIZED TO EXECUTE THIS DOCUMENT ON BEHALF OF THE PATIENT, AND THAT I ACCEPT THE TERMS HEREOF.

______________________________	______________________________
Patient Name	Signature (of Patient or Person Authorized to Sign on behalf of Patient)
Witness	Relationship to Undersigned (if not Patient)
Witness - Need Only if Signatures are Made By Mark (X)	Month Day Year Time (AM/PM)