

CONSENT FOR TREATMENT • NOTICE OF SBO POLICIES

I hereby consent to and authorize South Bend Orthopaedics Sports Medicine and Rehabilitation (SBO), its associated physicians, medical residents, nurse practitioners, students and other healthcare providers, to provide and perform such medical and surgical care, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and well-being. If I should not comply with the medical program of care provided or recommended by physician(s), or designated alternate(s), I understand that I then relieve my physician(s), designated alternate(s), associated medical staff, and SBO of all responsibility resulting from my action.

I also authorize South Bend Orthopaedics Sports Medicine and Rehabilitation (SBO), all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers (including but not exclusive of, private insurance, Medicaid, Medicare, Tricare, Disability, Workmen's Compensation, etc.).

I acknowledge that I have been given the ability to review SBO's policies (effective 11-01-04) including Financial Policy. I authorize SBO to call my name out in the waiting room.

****EXCESSIVE CANCELLATIONS OR NO SHOWS FOR APPOINTMENTS MAY RESULT IN DISCHARGE FROM PRACTICE****

FINANCIAL INFORMATION

INSURANCE: Please check with your insurance plan to verify that South Bend Orthopaedics is in your Preferred Provider Organization (PPO) Network. You are responsible for co-payments, deductibles, co-insurance. Co-pays are due at the time of appointment.

SELF-PAY: Down payment of \$205.00 due at visit.

DISABILITY: There will be a \$15.00 charge for each disability form and a 7-10 BUSINESS day waiting period for all disability forms.

FAMILY MEDICAL LEAVE ACT FORMS: There is no charge but there is a 7-10 BUSINESS day waiting period.

HANDICAP PARKING PERMITS: No charge.

MEDICAL RECORDS COPYING FEES: Payment is due prior to mailing or at the time of pick up.

- One dollar (\$1) per page for the first ten (10) pages.
- Fifty cents (\$.50) per page for pages eleven (11) through fifty (50).
- Twenty five cents (\$.25) per page for pages fifty-one (51) and above.
- Five dollars (\$5) per CD (X-Ray/MRI)
- Five dollars (\$5) per page printed (X-Ray/MRI films).
- Requests for medical records to be provided within two (2) working days will be processed with an additional ten dollar (\$10) fee.
- Please call our office for specific payment details if the following applies:
 - Medicaid patients
 - Request for consideration of financial hardship

NSF (NON SUFFICIENT FUNDS) CHECK FEE: \$15.00

Patient Signature _____ Date _____ Time _____ a.m./p.m.

Other Authorized Person _____ Relationship to Patient _____

Witness _____