ACCT NUMBER: _____
PATIENT NAME: _____
DATE: _____

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to insure you are aware of certain treatment, financial, and privacy policies.

Consent for Medical Treatment

I authorize the physicians of East Memphis Orthopedic Group and their healthcare team to render the evaluation and medical treatment needed. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary by my healthcare provider.

Consent for financial Responsibility

I acknowledge full and financial responsibility for services rendered by East Memphis Orthopedic Group I assign and authorize payments of medical insurance benefits to East Memphis Orthopedic Group directly and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fees, court cost, and collection agency costs in the event of default of payment of my charges. It is my responsibility to contact my insurance company and/or employer to verify that East Memphis Orthopedic Group and its licensed medical providers are participants in my insurance plan prior to treatment at East Memphis Orthopedic Group. East Memphis Orthopedic Group does not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance products, and I am responsible for the full payment of services at the time of rendering.

If my insurance plan requires a referral In order to be treated by an East Memphis Orthopedic Group provider, it is my responsibility to obtain the referral prior to being treated at East Memphis Orthopedic Group. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

East Memphis Orthopedic Group will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or with a plan East Memphis Orthopedic group does not participate, I am required to pay in full at the time of services are rendered. In the event my insurance company denies my claim or pays my claim as "out of network," I am responsible for the balance.

Some insurance companies may determine that certain orthopedic supplies that health care professionals prescribe for the patient's well being are not covered. I agree to pay for these supplies, in the event my insurance company denies coverage.

East Memphis Orthopedic Group accepts cash, check, bank debit card, MasterCard, Visa, Discover or American Express. Each instance of a returned check is subject to a $15 processing fee.

Signature of Patient / Guardian: _____ Date: _____

(Must be 18 years old or older to sign)