ORTHOPEDIC & SPORTS MEDICINE CENTER
OSMC

CONSENTS AND AUTHORIZATIONS

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF OSMC PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review the OSMC Privacy Notice.

×_____ _____
Patient Signature **Date**

_____ _____
Parent/Personal Representative Signature **Print Parent/Personal Representative Name**

If Personal Representative's signature appears above, please describe relationship to the patient: _____

CONSENT TO ACCESS EXTERNAL MEDICATION HISTORY

By signing this consent, it allows OSMC to obtain my external medication history from pharmacies. I understand that all prescriptions prescribed elsewhere and by other doctors will be electronically entered into my chart. This consent is valid for one year from the date signed and my medication list may be extracted each time I have an appointment with the physician or when having any communication with the physician or nursing staff. I am still responsible to notify the physician verbally of any changes in my medication or health history that may affect my care.

×_____ _____
Patient Signature **Date**

_____ _____
Parent/Personal Representative Signature **Print Parent/Personal Representative Name**

PHYSICIAN'S DISCLOSURE OF FINANCIAL INTEREST

Indiana law (I.C. 25-22.5-11) generally requires a physician to make certain written disclosures to a patient when the physician refers the patient to a health care entity in which the physician has a financial interest. While you are a patient (or the patient for whom you are the legal representative is a patient), an OSMC physician, may refer you to one of the health care entities listed below in which he/she may have a financial interest. In each case, you may choose to be referred to another health care entity other than the health care entities listed below:

OSMC MRI Center
OSMC Physical and Hand Therapy
OSMC Outpatient Surgery Center
OSMC Physicians
OSMC DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies)

David A. Beatty, M.D.	Craig W. Erekson, M.D.	Mark A. Klaassen, M.D.	Willis W. Stevenson III, M.D.
David A. Cutcliffe, M.D.	Gene W. Grove, M.D.	Scott J. Trumble, M.D.	J. Benjamin Smucker, M.D.
Jason J. Hix, M.D.	Sean M. Henning, D.P.M.	Christopher M. Annis, M.D.	Julia K. Pagano, D.P.M
Joseph M. Caldwell, M.D.	J. Mark Schramm, M.D.	Jonathan D. Schrock, M.D.	David J. Pope, M.D.
Edith M. Cullen, M.D.	Ryan P. Foreman, M.D.		Jeffrey R. Sonntag, D.O.

×_____ _____
Patient Signature **Date**

_____ _____
Parent/Personal Representative Signature **Print Parent/Personal Representative Name**

FINANCIAL POLICY / CONSENT FOR TREATMENT

Thank you for choosing OSMC as your health care provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our **Financial Policy** which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check or VISA, MasterCard, and Discover credit cards.

Regarding Insurance

We participate in many insurance plans and networks. It is the patient's responsibility to determine if the provider they are seeking services with participates in their health insurance plan or network. For some insurance, we accept assignment of benefits but in all cases, we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance plans.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $30.00 fee.

Minor Patients

The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, we will provide only emergency care unless other arrangements have been made prior to the service.

Medicare Once in a Lifetime Authorization (If applicable)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to OSMC for any services furnished to me by the physician and providers of OSMC. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine payments for related services.

Assignment of Insurance Benefits/ Consent

I authorize release of medical information to my insurance carriers for services rendered by the providers of OSMC and all affiliated corporations. In addition, I also authorize the release of payment information from my insurance carriers to OSMC and all affiliated corporations. In addition, I request payment(s) of authorized benefits be made directly to OSMC and all affiliated corporations. I understand I am responsible to pay all non-covered services.

Missed/No Showed Appointments

In order to better serve our patients, we ask that if you are unable to keep your appointment, you provide 24-hour advance notice whenever possible. Failure to attend your appointment without notice of cancellation will be considered a no show. OSMC reserves the right to charge a fee of $20 for no showed appointments. Failure to cancel or attend two consecutive appointments will result in the cancellation of all future scheduled appointments.

My health care provider may determine it is necessary to perform diagnostic tests, medical, and /or surgical procedures judged by him/her as necessary for my treatment and advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my provider as to the result of any treatments, examinations, and/or operative procedures performed in the office.

I authorize treatment by the attending provider.

I have read the Financial Policy. I understand and agree to the Financial Policy.

×_____	_____
Patient Signature	**Date**
_____	_____
Parent/Personal Representative Signature	**Print Parent/Personal Representative Name**