Harborside Spine & Sports Center
Consent to Treat, Release of Information, and Financial Policy

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider or assistant to examine and treat me. I understand that this could include medical treatment, lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of examination or treatment in this office.

RELEASE AND TRANSFER OF INFORMATION: I hereby authorize Harborside Spine and Sports Center (HSSC) to release to all insurance companies, third party payers (and to my employer if worker's compensation), and utilization review organizations, any medical or other necessary information for the purpose of obtaining authorization for medical services and for payment of my medical bills. I authorize HSSC to obtain and/or transfer clinical information about me to or from any other healthcare provider or health care agency including but not limited to physicians, hospitals, nursing homes, home care agencies and public health departments, in order to enhance the continuity of my care. I understand and agree that the information transfer will occur by means deemed most appropriate to the circumstances by HSSC including photocopy, electronic file transfer, fax, and computerized information systems.

NOTICE: I am notified, according to Michigan law, that as a patient of this practice, I may be tested for the presence of HIV or HIV antibody, Hepatitis C, and/or Hepatitis B without my consent in the event that any healthcare worker or other health facility employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or body fluids. This test is permitted under Michigan law and is for my protection as well as the protection of the staff of HSSC.

HEALTH INSURANCE: It is my responsibility to provide the practice with current insurance information. I will be asked to show my insurance card(s) at my visit. If current information is not obtained at the time of service, it will become my responsibility to pay until current information is provided to the practice. It is my responsibility to notify HSSC of any patient information changes (i.e. address, name, insurance information, etc).

My insurance policy is a contract between me and my insurance company. HSSC participates with, and accepts assignment from, most major payers, except Medicaid. As a courtesy, HSSC will file my claims for me and provide information as necessary for proper billing of charges. However, HSSC will not become involved in disputes between me and my insurance carrier. **I am ultimately responsible for the timely payment of my account.**

ASSIGNMENT OF BENEFITS: I authorize all medical and/or surgical benefits to which I am entitled to be paid to HSSC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I realize that I am responsible for payment of co-pays, deductibles, and coinsurance as required by my insurance plan.

PAYMENTS: I will pay all co-pays, deductibles, and coinsurance at the time of service. Co-payments are due at the time I check in at the front desk **PRIOR** to being seen by the provider. Unless other arrangements are approved by HSSC in writing, the balance on my statement is due and payable when the statement is issued. I can pay with cash, check or credit card.

PAYMENT ARRANGEMENTS: In the event that my total balance due is more than I am able to pay, I will make reasonable payment arrangements. Please contact HSSC billing office or practice manager to make such arrangements.

PAST DUE BALANCE: If my account becomes past due, I understand that HSSC will take the necessary steps to collect this debt and cancel future appointments. If payment is not made on this account, collection efforts will begin. If no resolution can be made, my account will be turned over to a collection agency and I will be discharged from the practice.

RETURNED CHECKS: The charge for a returned check is $25 payable by cash or money order. HSSC will apply this to my account in addition to the insufficient funds amount. I will be placed on a "Cash Only" basis following any returned check.

MISSED APPOINTMENTS: I will keep my scheduled appointments. I will call 24-hours before my appointment to cancel or reschedule. Failing to provide proper notice of cancellation will result in a $50.00 missed appointment charge for office visits and $150.00 charge for a missed injection or EMG. This charge is my responsibility and it is not covered by insurance carriers. Missing appointments on more than one occasion may result in the discharge of my care.

FORM COMPLETION: Disability, FMLA, and other forms are often requested to be completed by the physician. Many of the forms require completion of detailed medical history questionnaires. In many instances, it may be necessary to schedule an appointment for an assessment by the physician.

PRIVACY PRACTICES: I have been offered or provided a copy of the HSSC Notice of Privacy Practices for my review.

I have read and agree to the terms listed above.

_____ _____/_____/_____
Printed Name Date of Birth

_____ _____/_____/_____
Signature of Patient or Guardian Date

Spouse, relative, friend, or caregiver to whom pertinent information may be disclosed:

Name: _____ Relationship: _____

I authorize the staff at HSSC to leave messages on my phone at: (_____)_____-_____