Patient Name: _____ Account#_____

MEDICAL CONSENT

The undersigned consents to any x-ray examination, laboratory procedure and medical treatment rendered the patient under the general or special supervision of, or upon the advice of a physician.

_____ (Initial)

RELEASE OF THE INFORMATION

To extent necessary to determine liability for payment and to obtain reimbursement to Bones & Spine Surgery, INC. portions of the patient's records prescription, including the patient's medical records may be disclosed to any person or corporation (or any agent of such person or corporation) which is or may be liable for all or any portion of changes by Bones & Spine Surgery, Inc. (including but not limited to insurance companies, health care service plans, worker's compensation carriers and employers.)

_____ (Initial)

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my insurance benefits (otherwise payable to me) to Bones & Spine Surgery,Inc. Payment shall not exceed the group's regular charges for treatment. I understand that I am financially responsible to the medical group for charges not covered by this authorization. This authorization is valid for all family members who received medical treatment.

_____ (Initial)

FINANCIAL AGREEMENT

In consideration of the service to be rendered to the patient, the undersigned agrees, whether they sign as patient, as agent, or as financially responsible party, to pay all charges for patient's care to Bones & Spine Surgery, Inc. In accordance with the medical groups current rates and terms. (ALL CHARGES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.)

_____ (Initial)

AUTHORIZATION TO TRANSFER FUNDS

Should a credit balance appear on my account with Bones & Spine Surgery, Inc. during the course of my care, I authorize use of the credit balance to be applied to any unpaid balance due Bones & Spine Surgery for which I have accepted responsibility.

_____ (Initial)

The undersigned certifies that they have read the foregoing, received a copy of the same and accepts all its terms and conditions.

Patient Signature or Patient's Agent or Representative_____

Patient Name (Print)_____ Date_____

Witness_____ a) If a patient is a minor, the parent, having legal custody, a legal guardian, or a person authorized by them in writing, must sign b) If patient is incompetent, legal guardian or conservator must sign