

CONSENT FOR TREATMENT

I, _____ being the parent or legal guardian of _____, give my consent to all medical and surgical procedures and treatment, including but not limited to surgery, medical treatment, radiological examination, anesthesia, laboratory procedures, inpatient or outpatient services and medications that may be performed, administered or rendered by or under the specific or general instructions of my or my child's physicians or surgeons during this hospitalization or outpatient visit. In addition, I agree to abide by facility regulations designed to enhance the care and safety of patients, and I consent to the appropriate disposal of any specimen or other bodily materials removed during the course of my or my child's treatment.

CONSENT TO LEAVE MESSAGES

I, _____ give UHZ Sport Medicine Institute permission to:
Leave a message regarding my upcoming office visit, account information, and/or test results on my answering machine. **Yes No**

Leave a message with someone who may answer the phone at my residence. **Yes No**

Leave a message at my place of employment **Yes No**

Text me and/or email me to confirm appointment **Yes No**

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for the services provided that are deemed necessary by my or my child's physician(s), directly to this facility and its affiliates, attending and consulting physicians and allied health professionals. Where MEDICARE AND MEDICAID BENEFITS are applicable, I certify that the information given by me in applying for payment under Title XVII or XIX of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to this facility and its affiliates, attending and consulting physicians and allied health professionals on my behalf.

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GUARANTEE OF PAYMENT

I guarantee payment of any and all charges incurred, which are not covered or allowable by my insurance, or Medicare, if any, to this facility and its affiliates, attending and consulting physicians and allied health professionals. This includes any denial of payment due to lack of medical necessity or pre-certification/authorization (as maybe determined by a review organization), lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. It is further agreed that if this account is referred for collection, I will pay the costs of the collection including litigation costs and reasonable trial and appellate attorney's fees. An itemized bill is available from Patient Financial Services.

NOTICE OF PRIVACY PRACTICE AND RELEASE OF INFORMATION

I acknowledge that I was provided with a copy of the Baptist Health Notice of Privacy Practices describing how Baptist Health may use and disclose my health information under the federal law. Provided that Baptist Health continues its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and activities permitted under the federal privacy law, which are described in the Baptist Health Notice of Privacy Practices.

PATIENT'S CHOICE OF VENDOR:

Patient has been informed that it is his/her right to choose a vendor to provide durable medical equipment ("DME"). DME includes, but is not limited to, braces, post-operative shoes, and cast shoes. There is a DME provider on-site at the UHZ Sports Medicine Institute ("UHZ") office as a convenience to UHZ's patients. Patient can choose to select this on-site DME provider, or seek an off-site DME provider. The choice of a DME provider rests with the Patient. If Patient chooses the DME provider on-site at UHZ, then Patient will receive a **separate bill** from that on-site DME provider for the items and services it furnishes to Patient. DME may or may not be covered by Patient's insurance (if any). The DME provider on-site at UHZ is **not** affiliated with the UHZ, its physicians, Doctors Hospital or Baptist Health South Florida.

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