Authorization to Release Information, Consent to Treatment and Assignment of Benefits

Patient Name_____ Patient Account number_____

I certify that the information that I have reported with regards to my insurance coverage is correct.

I hereby authorize NEBRASKA ORTHOPAEDIC CENTER, P.C. to file claims and release any medical information necessary to process these claims. I also authorize payments to be made directly to NEBRASKA ORTHOPAEDIC CENTER, P.C. for the services provided to me (or the above-named patient), and authorize NEBRASKA ORTHOPAEDIC CENTER, P.C. to render appropriate treatment/procedures relating to the diagnosis.

I understand that I am financially responsible to NEBRASKA ORTHOPAEDIC CENTER, P.C. for the services provided to me or my dependent. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance carrier. I also agree to pay the cost of collection and/or court costs and reasonable fees should this be required.

I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, including but not limited to, third party debt collectors, now and in the future, may be used as a means to contact me for any reason, including but not limited to, billing and collecting payment, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

I agree that Nebraska Orthopaedic Center, P.C. may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)

I hereby authorize Nebraska Orthopaedic Center, PC to appeal all claims for charges I will incur as a patient of this practice.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)