2701 Cross Timbers, Suite 232 Flower Mound, TX 75028
6805 West Northwest Highway Dallas, TX 75225
(972)347-4783/(972)347-4916 Fax

Consents and Authorizations

Provider: We must emphasize that as medical care providers our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer, and the insurance company. We are not a party to your contract. (This does not pertain to carriers with whom we have HMP/PPO contracts.)

Consent to Treatment: I hereby grant Southwest Pediatric Orthopedics the authority to treat and examine me/my dependent and order the examination, test, treatment and other clinical services necessary for my care and treatment.

Insurance Authorization: I hereby authorize Southwest Pediatric Orthopedics to furnish my insurance carrier with information concerning my illness and treatment. I also authorize electronic transmission of my insurance claim to the carrier.

Medicare Assignment: I hereby request that payment of authorized Medicare Benefits be made to Southwest Pediatric Orthopedics for services provided.

Consent to Release Medical Records: I hereby authorize Southwest Pediatric Orthopedics permission to release medical records or patient information to any and all referring physicians, hospitals, auxiliary services referred by this practice, or firms that have been your representative.

Consent to Electronically Transmit (FAX): I hereby authorize Southwest Pediatric Orthopedics permission to electronically transmit (FAX) copies of medical records or patient's information to any and all referring physicians, hospitals and auxiliary services referred by this practice. It is my understanding that there are instances when electronically transmitted information may go somewhere other than the number dialed due to switching malfunctions at the phone company and Southwest Pediatric Orthopedics will not be held responsible.

Reasonable and Customary: I understand that Southwest Pediatric Orthopedics employees are specialists and that fees charged may be in excess of what my insurance carrier considers reasonable and customary. I understand that if my insurance company fails to pay, Southwest Pediatric Orthopedics will not be held responsible.

Payment of Office Visit: Payment will be rendered in full at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1 & ½% finance charge (18% APR) may be added to my account. Payments may be made in the form of cash, check, American Express, Discover, MasterCard, or Visa. A $25.00 service fee will be charged on all returned checks.

Assignment of Benefits: I hereby assign all past, current and future medical benefits, if any, otherwise payable to me for services rendered directly by Southwest Pediatric Orthopedics. I authorize Southwest Pediatric Orthopedics to sign and deposit monies received on behalf of my medical care.

No Show Policy: I acknowledge that I must give a 24 hours notice for cancellations or will be subject to a $50.00 no show charge.

I understand that I can revoke at anytime except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Additionally, I acknowledge that I fully comprehend the consents and authorizations and that any questions I had were discussed with my physician and/or the staff.

_____ _____
Name of Patient (Print) **Date**

_____ _____ _____
Patient Representative (Print) **Signature of Representative** **Date**

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Relationship of Patient Representative to Patient