GULF COAST ORTHOPEDICS

1001 School Street Houma, Louisiana 70360

Authorization for Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Gulf Coast Orthopedics. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Gulf Coast Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Gulf Coast Orthopedics is hereby authorized or disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians and/or coaches. I agree that Gulf Coast Orthopedics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes, I also authorize research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient of any other party liable to the patient, said benefits are hereby assigned to Gulf Coast Orthopedics for application the patient's bill. The undersigned, and/or patient agrees to be responsible for changes not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all changes for services such as, DURABLE MEDICAL SUPPLIES, SYNVISC, SUPARTZ, SYNVISC ONE, and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including collection fee, attorney fees, and/or court cost, if such be necessary. I waive and forever, my right of exemption under the laws of the Constitution of the State of Louisiana and any other state. All delinquent balances shall bear interest at the legal rate.

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits, either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in paying for my treatment (section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I understand that under no circumstances will Gulf Coast Orthopedics be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

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UNDERSIGNED (Patient's Signature)

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Signature - if signed by Undersign's Authorized Agent

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Witness

____
Relationship to undersigned

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Witness - need only if signatures are made by (X)

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Date Time of Signing