



Nebraska Orthopaedic A S S O C I A T E S

Orthopaedics • Sports Medicine • Joint & Hand Specialists

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FAX 552-2720

OAKVIEW MEDICAL BUILDING
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Omaha, NE 68144
(402) 637-0400
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JENNIE EDMUNDSON HOSPITAL
1 Edmundson Place, Suite 200
Council Bluffs, IA 51503
(712) 396-4020
FAX 396-4025

CONSENT TO TREAT

- I give my consent for diagnosis and treatment to Nebraska Orthopaedic Associates under the care of the attending physician or physician assistant. My consent includes, but is not limited to x-ray, examination, charting, or other office services and procedures or consultation with another physician rendered to the patient at the discretion of the attending provider.

AUTHORIZATION FOR RELEASE OF INFORMATION

- I hereby authorize the release of my medical records and x-rays by Drs. O'Neil, Ferlic, Canedy, M. Goebel, Hagan, Burt, S. Goebel, Urban and Bruggeman to my attending physician, hospitals and third party payer (whether an insurance co., government agency, employer, or self insurance employer or utilization review organization).

ASSIGNMENT OF BENEFITS

- I hereby assign to said physician all right, title and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to said physician and I will be responsible for any charges accrued and not paid by the insurance company. **I understand I am responsible for all co-pays, deductibles, co-insurance and any non-covered services.**

ONE TIME AUTHORIZATION FOR MEDICARE

- I request that payment of authorized Medicare benefits be paid on my behalf to Drs. O'Neil, Ferlic, Canedy, M. Goebel, Hagan, Burt, S. Goebel, Urban, and Bruggeman for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financial Administration and its agents if needed to determine if benefits are payable for related services.

RECEIPT OF PATIENT'S RIGHTS AND RESPONSIBILITIES

- I have received a copy of the office Patient's Rights and Responsibilities notice. I agree to uphold my patient responsibilities as outlined to the best of my ability.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received a copy of the Notice of Privacy Practices from Nebraska Orthopaedic Associates.

THIS DOCUMENT REMAINS IN EFFECT UNLESS REVOKED IN WRITING

X _____
SIGNATURE OF PATIENT OR GUARDIAN

DATE