Midwest Sports Medicine
& Orthopaedic Surgical Specialists, Ltd.
901 W. Biesterfield Road, Suite 300
Elk Grove Village, IL 60007
Phone: 847-437-9889
Fax: 847-437-4149

975 E. Nerge Road, Suite N-140
Roselle, IL 60172
Phone: 847-437-9889
Fax: 847-944-1240

UNIVERSAL CONSENT FORM

PATIENT NAME: _____

CONSENT FOR TREATMENT

It is my wish to be treated by **Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd**. and its affiliated healthcare providers including: **Open MRI Imaging Specialists, LLC.; The Center for Physical Therapy at Midwest Sports Medicine and Midwest Center for Pain Management, Ltd. (hereinafter collectively referred to as "Midwest Sports Medicine".)** I give permission for Midwest Sports Medicine's physicians, physician assistants, and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication, examinations, X-rays, tests or minor procedures that my Midwest Sports Medicine physician determines to be necessary. I understand my Midwest Sports Medicine physician will explain to me the nature of my condition, his/her recommended treatment and any associated risks involved. I also understand that he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been given an explanation and a copy of Midwest Sports Mecine's "HIPAA Notice of Privacy Practices" and understand that I may call Midwest Sports Medicine's Privacy Officer if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by State and Federal laws. Midwest Sports Medicine may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices. I understand that, except as regulated by law, my medical record information will not be released should I refuse to sign this form. Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize payment to Midwest Sports Medicine and its physicians (who agree to accept this assignment) and assign all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers Compensation, or any other health plans under which I may be entitled to reimbursement. I understand that I am financial responsible to Midwest Sports Medicine for charges not covered by my insurance and this assignment.

In consideration of medical services provided by Midwest Sports Medicine to the above-identified patient, I agree to pay to Midwest Sports Medicine all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/or reasonable attorney fees. The costs of collection include a $75 collection agency service fee and/or up to 50% collections cost. I agree to pay Midwest Sports Medicine a $50 NSF fee for any returned checks. I agree to pay Midwest Sports Medicine a $100 no show fee for any MRI service that I do not call and cancel/reschedule within 24 hours. I hereby authorize my attorney to pay Midwest Sports Medicine any outstanding balances due immediately upon receipts of any Workers Compensation and/or Third Party Insurance Cases settlement.

DISCLOSURE OF OWNERSHIP

Midwest Sports Medicine is required to inform you that several of our physicians are investors of Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd., Open MRI Imaging Specialists, LLC, The Center for Physical Therapy at Midwest Sports Medicine and Midwest Pain Center for Management.

Medicare Certification and Authorization: I certify that the information given by me in applying for payment under the XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payor as it applies to my Medicare health care insurance.

X_____
Initials of Guarantor/Patient

Sharing of Medical Information: I hereby authorize Midwest Sports Medicine to share my registration , medical history, billing, insurance information, etc. within its own network. The sharing of information should avoid having to complete an identical form a second time and allow our staff to pre-approve tests or procedures more quickly, thereby expediting your medical care when utilizing other services within Midwest Sports Medicine.

X_____
Initials of Guarantor/Patient

I have read and understand the above information and agree to its content:

_____ _____
Signature (Patient/Parent/Legal Guardian) Date

_____ _____
Signature of Guarantor (if other than above) Date

_____ _____
Signature of Witness Date