ASHEVILLE ORTHOPAEDIC ASSOCIATES, P.A.

Patient Name: **DOB:** **Account #:**

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Asheville Orthopaedic Associates. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Asheville Orthopaedic Associates, P.A. to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____ Date _____

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Asheville Orthopaedic Associates, P.A., I acknowledge recognition of the fact that the evaluation and treatment received from Asheville Orthopaedic Associates, P.A. is advised and deemed necessary to be the judgment of the Physician.

- I authorize the physicians of Asheville Orthopaedic Associates and their healthcare team to render the evaluation and medical treatment needed. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary by my healthcare provider.

X Signature_____ Date _____

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Asheville Orthopaedic Associates, P.A. to disclose my personal medical information to the following individual(s).

____Asheville Orthopaedic Associates, P.A. may disclose my medical information only in my presence.

____Asheville Orthopaedic Associates, P.A. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.

____I understand that this consent may be revoked by me at any time by written notice of Asheville Orthopaedic Associates.

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

_____ **Person(s) listed above age 18 or older may pick up prescription when I am not present.**

X Signature_____ Date _____