MEDICAL TREATMENT AURTHOIZATION AND FINANCIAL RESPONSIBILITY NOTICE

I HEREBY:

1. Consent to the administration of medical treatment by Adam J. Olscamp, MD and/or Ryan L. Smith, PA-C (hereafter referred to as Olscamp Orthopedics) or other qualified parties under the direction of our providers as may be necessary.
2. Consent to Olscamp Orthopedics furnishing or retrieving my medical information by verbal, written and/or fax to/from my family physician, physical therapist, etc involved in my medical care. This consent is revoked upon written notification.
3. Acknowledge that a copy of the Notice of Privacy Practices for Olscamp Orthopedics is available upon request.
4. Acknowledge that I am about to incur indebtedness to Olscamp Orthopedics for professional services rendered and agree to pay all amounts as services are rendered. In the event of nonpayment, I agree to make satisfactory arrangements with Olscamp Orthopedics to pay said account.
5. We see patients from many different insurance plans and it is impossible for us to know all the covered benefits, co-payments and deductibles for each individual plan. While it is our intention to assist you, it is your responsibility to ensure that all services rendered by Olscamp Orthopedics are paid in full.
6. Have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I hereby authorize Olscamp Orthopedics to furnish my insurance company all information which said insurance company may request concerning my illness or injury.
7. The policy in our office is that the parent who requests treatment for the child is responsible for all fees for services rendered. No absent parent billing.
8. Assignment of Proceeds-In the event I have an unpaid balance to the providers of Olscamp Orthopedics, I grant and assign to Olscamp Orthopedics proceeds from any settlement or court determination related to injuries for which the providers of Olscamp Orthopedics have treated me to satisfy my debt to Olscamp Orthopedics. I understand that even though I may have insurance coverage, **I am responsible for payment of services**. A photocopy of this assignment is as valid as the original.

DISCLOSURE OF OWNERSHIP

ADAM J. OLSCAMP, MD HAS A FINANCIAL INTEREST IN THE NORTHWEST SPECIALTY HOSPITAL. DR. OLSCAMP ONLY DOES HIS ELECTIVE PROCEDURES AT NORTHWEST SPECIALTY HOSPITAL. IF YOU WISH TO HAVE YOUR SERVICES DONE AT AN ALTERNATE FACILITY WE CAN REFER YOU TO ANOTHER PROVIDER TO ACCOMMODATE THIS REQUEST.

PLEASE SIGN THAT YOU HAVE BEEN GIVEN THIS INFORMATION AND AGREE TO ITS CONTENT.

PATIENT SIGNATURE: X____ DATE:____________________

Or

SIGNED BY:____ DATE:____________________

Parent_______ Guardian________ Power of Attorney_________