2406 East Empire
Bloomington, Illinois 61704
Phone: (309)663-9300

Consent to Medical Treatment

I consent to medical examination/treatment by Orthopedic and Sports Enhancement Center, LLC (OSEC). I understand that the physician may request assistance from medically trained individuals who may be employees or agents of this facility. Authorized medical, nursing, and allied health professionals who are not employees of this facility may accompany and/or participate with the physician and staff in the observation and delivery of care and I consent to such participation. I acknowledge that no guarantees have been made to me in regards to the outcome of this care and/or treatment.

Release of Information

I have been given a copy of the privacy policy of OSEC and understand that my protected health information may be released to substantiate claims; that OSEC has the right to appeal any denial that may be made by my insurance company and has the right to receive complete documentation regarding any denials.

Responsibility for Payment

OSEC is authorized to submit claims for services rendered to the insurance company/companies as indicated by me. I understand that I am responsible for payment of services rendered regardless of any liability claims, insurance, lack of insurance or insurance plan limitations. I agree to make payment in full at the time of service for any copay, coinsurance, deductible amounts for which I am responsible, and/or non-covered services (for which OSEC gives me prior notification) unless prior arrangements have been made with OSEC. I understand that it is my responsibility to contact my insurance company to determine if prior approval for services is required by my plan and I will notify OSEC if prior approval is needed. I also understand that I will be held responsible for payment of any collection fees, attorney fees and/or court costs incurred should collection proceedings become necessary.

I understand the content and significance of this form and certify that the personal and insurance information provided is true and correct. My signature shall remain in effect until revoked in writing.

Signature of Patient or Legal Guardian: ____

Relationship to Patient: _____________________________________ Date: __________________