Patient's Name: _____DOB: _____

Email: _____Acct #: _____

PATIENT CONSENT **

Please provide the name(s) & address(es) of any individuals with whom we may share your medical information:

Name: _____ **Name:** _____

Address: _____ **Address**: _____

Relationship/DOB: _____ **Relationship/DOB:** _____

Phone#: _____ **Phone#:** _____

I hereby authorize Syracuse Orthopedic Specialists, PC (SOS) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for surgical/medical services to be sent directly to Syracuse Orthopedic Specialists. I hereby authorize Syracuse Orthopedic Specialists, PC to place my signature on file with Upstate Medicare Claims Division for the purpose of billing Medicare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I accept responsibility for all medical charges not covered by insurance. I agree to pay any co-pays and/or balances at the time of service unless other arrangements are made in advance. I accept financial responsibility. Correspondence regarding medical charges will be sent to the address of the insurance holder. I assume responsibility for all reasonable collection costs, including attorneys' fees.

I authorize Syracuse Orthopedic Specialists, PC to leave messages on my answering machine/voice mail pertaining to appointments or payment issues and to send correspondence to the address provided for the insurance holder unless other arrangements are made in advance.

I consent to the release of any medical information about me and any other individual for whom I can give consent to my health plan and any health care providers involved in caring for me or such individual, as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations. **(** This does not replace the required HIPAA written authorization for applicants other than treatment, payment, of health care operations.)**

Printed Name: _____ DOB: _____ Date: _____

Signature: _____ Relationship to Patient: _____