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CONSENT FOR SERVICES / RELEASE OF INFORMATION

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my physician or his/her designees, determine to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment.

RELEASE OF INFORMATION: I hereby authorize Headwaters Orthopedics to release medical and billing information to governmental agencies, intermediaries, insurance companies, and utilization review companies who may be responsible for payment of benefits. This may include verbal, written or faxed information. I further authorize the release of information from my medical records to health care providers and physicians who have been providing care to me and/or who will be continuing my medical care after discharge. I authorize release of information to Worker's Compensation if requested. I release Headwaters Orthopedics from any liability that may arise from the release of the information requested.

INSURANCE CONSENT: I request that payment of authorized benefits be made to Headwaters Orthopedics for any services furnished to me. I authorize this facility to release to HCFA, and other accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and study.

EDUCATION/RESEARCH: The Headwaters Orthopedic team may include students. If I choose not to have students care for me, I am responsible to notify Headwaters Orthopedic staff. From time to time Headwaters Orthopedics participates with medical studies and my medical record may be used for this reason.

CONSENT FOR TESTING OF BLOOD: I understand that while receiving and providing health care, persons may accidentally be exposed to my blood or body fluids. If this rare event occurs, I understand that a sample of my blood may be tested for the presence of infection with HIV, the AIDS virus and hepatitis virus. The tests are necessary to help protect and counsel the exposed person. I understand that if I am involved in an exposure incident the results of the test will be part of my medical record and will not be released except with my prior consent or as required or permitted by law.

GUARANTEE OF ACCOUNT: I agree to pay Headwaters Orthopedics for all charges for services not covered by any third party payor. Finance charges may be applied to the unpaid balance after 90 days.

CERTIFICATION: I have read each of the above statements and/or have had them read to me. I have received a copy and being a patient, guarantor, or being duly authorized by the patient, do agree and accept its terms. (EXCEPT WHERE NOTED)

______________________________	______________________________
Patient or Authorized Signature	Relationship to Patient
______________________________	______________________________
Employee Signature	Date

Reason patient is unable to sign: ____ minor _____physical or mental disability

Other, please state ____

1/5/05 Form