Myers Sports Medicine and Orthopaedic Center, L.L.C.

PATIENT ACKNOWLEDGEMENT

By signing this document below and by initialing each paragraph, the patient or responsible party listed above acknowledges they have read and understood the following:

PAYMENT RESPONSIBIBITY

____ Payment for office services or the co-payments and/or the co-insurance is payable when service is rendered. Payment for medical services is between Myers Sports Medicine and Orthopaedic Center and the patient/responsible party. Therefore, Myers Sports Medicine and Orthopaedic Center cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness, liability claim, (4) claim where patient is or will be represented by an attorney, and \/or (5) claim to be settled in a court of law.

INSURANCE LIMITATIONS

____ Most insurance carriers require a written referral from a Primary Care Physician in advance of service provided by Myers Sports Medicine and Orthopaedic Center. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurances. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. Myers Sports Medicine and Orthopaedic Center will file a patient's insurance as a courtesy.

ASSIGNMENT OF MEDICAL BENENFITS

____ The patient or responsible party certifies that information provided relative to injury, illness, and insurance coverage is both true and correct. By signing this form the patient or responsible party authorizes payment of insurance benefits or proceeds from any liability claim or legal or court settlement to be assigned to Myers Sports Medicine and Orthopaedic Center to the extent that t heir charges are paid in full.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

____ I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize t he release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS

____Myers Sports Medicine and Orthopaedic Center utilizes Physician Assistants in our offices. Physician Assistants may provide care for you during your visit. By signing this form you give permission to have Physician Assistants assist in your care.

CONSENT TO TREAT

____I hereby voluntary consent to my treatment at Myers Sports Medicine and Orthopaedic Center and authorize such treatments, examinations and diagnostic procedures (including by not limited to the use of lab and radiographic studies) as ordered by my attending/ covering physician.

Patient Name_____ Account #_____

Signature of Patient/Responsible Party _____ Date_____

Witnessed By _____ Date_____