Patient Agreement — Consent Form

Date: _____

Name: _____

Patient DOB: _____

Phone: _____

Address: _____

Authorization for Medical Treatment:

The undersigned consents to the medical treatment considered necessary to be performed by the physician and the employees of TMI Sports Medicine & Orthopedics, including in-office injections determined to be indicated by the physicians. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy:

TMI Sports Medicine & Orthopedics will use and disclose your personal health information to treat you and to receive payment for the care we provide. We have prepared a detailed NOTICE of PRIVACY PRACTICES information sheet to help you better understand our policies regarding your personal health information. The terms of the notice may change at any time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information:

TMI Sports Medicine & Orthopedics is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance companies, financially responsible parties, other treating physicians, athletic trainers, physical medicine personnel and/or coaches. I also authorize TMI Sports Medicine & Orthopedics to utilize medical information obtained during the course of treatment in medical research and education programs, provided my name is not revealed and my privacy is maintained and protected.

Assignment of Benefits:

In the event the undersigned is entitled to benefits of any kind arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to TMI Sports Medicine & Orthopedics for application on the patient ' s account. The undersigned and/or patient agree to be responsible for the charges not covered by the assignment, including deductibles, coinsurance and copayments as contracted by each party.

Financial Agreement:

The undersigned agrees that in consideration for services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services such as durable medical supplies and Orthovisc and any other non-covered charges. The undersigned agrees to assign payment for unpaid charges from services provided by physicians and personnel employed by TMI Sports Medicine & Orthopedics. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account to collections, I agree to pay all monies due, including the collection fee, attorney fee and court fee, if such become necessary. I waive now and forever my right of exemption under the laws of the Constitution of the State of Texas and any other state. All delinquent balances shall bear interest at the legal rate.

Medicare (CMS) Authorization:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefit either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

Notice of Ownership:

Our physicians are owners in various medical facilities across the metroplex including Baylor Scott & White Las Colinas Surgical Hospital, Trinity Park Surgery Center, and Dallas Joint and Spine. Ownership in a facility helps facilitate control over quality of care. If you have any questions, please consult your physician.

SMS Communication Consent:

By providing my phone number, I consent to receive SMS (text) messages from TMI Sports Medicine & Orthopedics regarding appointment reminders, scheduling, treatment updates, and other healthcare-related communications. Message frequency may vary. Message and data rates may apply.I understand that I may opt out of receiving SMS messages at any time by replying STOP, and I may request assistance by replying HELP. I understand that opting out of SMS messages may impact my ability to receive timely information regarding my care.I acknowledge that SMS communications may not be fully secure and understand the risks associated with electronic communication.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE AND ACCEPT THE TERMS OF THIS CONSENT.

Patient / Legal Guardian Signature: _____

Printed Name: _____

Relationship (if not patient): _____

Date: _____