

**Patient Name:** \_\_\_\_\_

**Consent For Treatment**

It is my wish to be treated by Hinsdale Orthopaedics and its affiliated healthcare provider, Hinsdale Orthopaedic Imaging Center. I give permission for Hinsdale Orthopaedics physicians, physician assistants and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication, examinations, x-rays, tests or minor procedures that my Hinsdale Orthopaedics physician determines to be necessary. I understand my Hinsdale Orthopaedics physician will explain to me the nature of my condition, his/her recommended treatment and any associated risks involved. I also understand that he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as the diagnosis or result of examination or treatment in this facility.

**Acknowledgement of Receipt of Privacy Notice**

I have been given an explanation and a copy of Hinsdale Orthopaedics' "HIPAA Notice of Privacy Practices" and understand that I may call Hinsdale Orthopaedics' Privacy Official if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by State and Federal laws. Hinsdale Orthopaedics may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices.

I understand that, except as regulated by law, my medical record information will not be released should I refuse to sign this form. Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

**Assignment of Benefits and Guarantee of Payment**

I hereby authorize payment to Hinsdale Orthopaedics and its physicians (who agree to accept this assignment) all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers Compensation, or any other health plans under which I may be entitled to reimbursement. I understand that I am financially responsible to Hinsdale Orthopaedics for charges not covered by my insurance and this assignment.

In consideration of medical services provided by Hinsdale Orthopaedics to the above-identified patient, I agree to pay to Hinsdale Orthopaedics all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/or reasonable attorney fees. I hereby authorize my attorney to pay Hinsdale Orthopaedics any outstanding balances due immediately upon receipt of any Worker's Compensation and/or Third Party Insurance Case settlement.

**Disclosure or Ownership and Outside Relationships**

Hinsdale Orthopaedics is required to inform you that several of our physicians are investors in Hinsdale Orthopaedic Imaging Center and Salt Creek Surgery Center. Also, physicians at Hinsdale Orthopaedics may have a consulting agreement, royalty arrangement or serve on an advisory board for a company that manufactures medical equipment or devices used in your care. If you have questions about any of these relationships between Hinsdale Orthopaedics, its physicians and/or staff and these companies, please inquire of your physician. Your physician will be able to specifically address your unique medical situation and the impact of any potential outside relationships. If you need additional information or have additional concerns, you may also contact Hinsdale Orthopaedics administration.

**Medicare Certification and Authorization:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payor as it applies to my Medicare health care insurance.

Initials of Guarantor/Patient: \_\_\_\_\_

**I have read and understand the above information and agree to its content:**

Signature (Patient/Parent/Legal Guardian/Guarantor) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

<p><b>Hinsdale</b> 550 West Ogden Ave. Hinsdale, IL 60521 P: 630.323.6116 F: 630.323.6169</p>	<p><b>Naperville</b> 2940 Rollingridge Rd. Suite 102 Naperville, IL 60564 P: 630.579.6500 F: 630.579.5860</p>	<p><b>Joliet</b> 951 Essington Rd. Joliet, IL 60435 P: 815.744.4551 F: 815.744.4756</p>	<p><b>New Lenox</b> 1870 Silver Cross Blvd. Suite 200 New Lenox, IL 60451 P: 815.462.3474 F: 815.462.1032</p>	<p><b>Westmont</b> 1010 Executive Ct. Suite 250 Westmont, IL 60559 P: 630.323.6116 F: 630.323.5610</p>
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