

MEDICAL TREATMENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY NOTICE

I HEREBY:

1. Consent to the administration of medical treatment by Adam J. Olscamp, MD, Roger C. Dunteman, MD, William F. Sims, MD, Douglas P. McInnis MD, or Terrance C. Tisdale, MD (hereafter referred to as OSSM-Orthopedic Surgery & Sports Medicine) or other qualified parties under the direction of our providers as may be necessary.
2. Consent to OSSM furnishing or retrieving my medical information by verbal, written and/or fax to/from my family physician, physical therapist, etc involved in my medical care. This consent is revoked upon written notification.
3. Acknowledge that I have a copy of the Notice of Privacy Practices for OSSM.
4. Acknowledge that I am about to incur indebtedness to OSSM for professional services rendered and agree to pay all amounts as services are rendered or within NINETY (90) DAYS from the statement date. In the event of nonpayment within said NINETY (90) DAYS, I agree to make satisfactory arrangements with OSSM to pay said account.
5. Have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I hereby authorize OSSM to furnish my insurance company all information which said insurance company may request concerning my illness or injury.
6. The policy in our office is that the parent who requests treatment for the child is responsible for all fees for services rendered. No absent parent billing.
7. Assignment of Proceeds-In the event I have an unpaid balance to the doctors of OSSM, I grant and assign to OSSM proceeds from any settlement or court determination related to injuries for which the providers of OSSM have treated me to satisfy my debt to OSSM. I understand that even though I may have insurance coverage, I am responsible for payment of services. A photocopy of this assignment is as valid as the original.

DISCLOSURE OF OWNERSHIP

ADAM J. OLSCAMP, MD AND ROGER C. DUNTEMAN, MD HAVE A FINANCIAL INTEREST IN THE NORTHWEST SPECIALTY HOSPITAL. YOU MAY CHOOSE TO HAVE YOUR SURGERY AT EITHER NORTHWEST SPECIALTY HOSPITAL OR KOOTENAI HEALTH. PLEASE NOTIFY YOUR DOCTOR IF YOU HAVE A PREFERENCE.

PLEASE SIGN THAT YOU HAVE BEEN GIVEN THIS INFORMATION AND AGREE TO ITS CONTENT.

PATIENT SIGNATURE: X _____ DATE: _____

Or

SIGNED BY: _____ DATE: _____

Parent _____ Guardian _____ Power of Attorney _____