OSSM MEDICAL TREATMENT AUTHORIZATION AND FINANCIAL RESPOSIBILITY NOTICE

I HEREBY:

1. Consent to the administration of medical treatment by Roger C. Dunteman, MD, William F. Sims, MD, Douglas P. McInnis, MD, Jonathan S. King, MD, Gregory R. Keese, MD, Scott A. Brown, DO, or Lucas A Anderson, MD (hereafter referred to as OSSM-Orthopedic Surgery & Sports Medicine) or other qualified parties under the direction of our provider as may be necessary.
2. Consent to OSSM furnishing or retrieving my medical information, 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 a copy of Notice of Privacy Practices for OSSM is available upon request.
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. In the event of nonpayment I agree to make satisfactory arrangements with OSSM to pay said account 208-664-2175 Ext 219.
5. We see patients from many different insurance plans and it is impossible for us to know all the contracted plans and covered benefits, co-payments and deductibles for each individual plan. While it is our intention to assist you, it is your responsibility to ensure that all services rendered by OSSM are paid in full.
6. 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.
7. 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.
8. 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 SERVICES.** A photocopy of this assignment is as valid as the original.
9. I acknowledge that OSSM DOES NOT accept out of state Workman's Comp Claims OR out of state aid. If this information is given after treatment has begun, your account will be treated as a self/cash pay account.

DISCLOSURE OF OWNERSHIP

ROGER C. DUNTEMAN, MD HAS A FINANCIAL INTEREST IN THE NORTHWEST SPECIALTY HOSPITAL.
WILLIAM F. SIMS, MD HAS A FINANCIAL INTERST IN PLEASANT VIEW SURGERY CENTER. DOUGLAS P. MCINNIS, MD, JONATHAN S KING, MD AND SCOTT A. BROWN, DO HAVE A FINANCIAL INTEREST IN KOOTENAI OUTPATIENT SURGERY. ALL DOCTORS HAVE A FINACIAL INTEREST IN INLAND NORTHWEST IMAGING. ALL DOCTORS HAVE FINANCIAL INTERST IN ORTHOPEDIC THERAPY INSTITUTE. YOU MAY CHOOSE TO HAVE YOUR SERVICES DONE AT AN ALTERNATE FACILITY. **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:______________________________ DATE:____________
Or
SIGNED BY:____________________________________ DATE:____________

PARENT_______ GUARDIAN_________ POWER OF ATTORNEY_______