UNOVA
HIP&KNEE
CENTER

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MESSAGE TO THE PATIENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) to be performed so that you may make the decision whether or not to undergo any recommended treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite offices. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

AUTHORIZATION / CONSENT TO TREATMENT

I the undersigned, request and authorize UNOVA Health and all its physicians, surgeons, technicians, nurses, and other qualified personnel, whether employed directly by UNOVA Health or brought in on a consulting basis, to provide any medical/surgical treatment, laboratory and diagnostics tests, and other healthcare services which my physician or designee(s) may deem necessary or beneficial for my health.

I understand the results of any treatments, tests or care cannot be guaranteed. I also understand that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

I understand that medical, nursing, and other health care personnel in training may be observing and participating actively in my care under the supervision of authorized personnel. I hereby give my consent to such observations and/or participation.

RELEASE OF INFORMATION

To obtain payment for services, I authorize UNOVA Health to furnish and release to my insurance carrier(s) or their representatives insuring the patient named, any or all portions of my medical record which may be necessary for completion of my patient care insurance claims. I understand that billing agencies for specialized services such as radiology, pathology services, and anesthesia will also receive information necessary for billing.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

*I realize my health insurance is billed as a courtesy**. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance, unless regulatory requirements prohibit, or my insurer has an agreement with UNOVA Health not to bill the balance to your account.***

I hereby assign benefits from any and all accident, medical and third-party insurances and authorize my carrier to make payment directly to UNOVA Health. I assign to UNOVA Health any and all rights to money owed to me in relation to evaluation and/or treatment performed by UNOVA Health staff and physicians up to the amount of the billed services.

I certify that I have read and completely understand the above statements. I herby consent fully and voluntarily to the contents of this form.

_____	_____	_____	_____
Patient Name (Print)		Date of Birth	Today's Date

_____ _____

Signature (Patient or Legal Representative for Patient) Relationship to Patient