TEXAS ORTHOPAEDIC ASSOCIATES

A DIVISION OF OrthoLoneStar

Consent to Treat- Fall 2021 Injury Clinic

1. I hereby authorize employees and agents of Texas Orthopaedic Associates, Division of OrthoLoneStar (including physicians, physician assistants, and other employees and staff members) to render medical evaluations and care to the patient listed below. I understand that in connection with the patient's treatment, photos or videos may be taken.

2. I understand that only the **first** visit of injury clinic is complimentary, and any necessary follow up visits or services needed will be performed during normal business hours. Therefore, I will provide all personal insurance information and/or school insurance claim forms in case further visits, x-ray imaging, other diagnostic studies (i.e. MRI, CT scans) and/or durable medical equipment (i.e. braces, crutches) are needed.

3. I understand that insurance coverage and verification is not a guarantee of payment, and I will be ultimately responsible for any balance due after my insurance has paid or denied my claim(s). Payment of your deductible and coinsurance will be required for your calculated portion of our fees, based on your insurance contract, in advance of any scheduled surgical procedures and diagnostic testing. Any balance remaining after your health plan pays its portion is your responsibility and payment for balance is due upon notification from our office. Any overpayment will be refunded directly to you.

Treatment Date: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

Print Legal Guardian's Name: _____

Patient or Legal Guardian Signature: _____ Date Signed: _____

Authorization to Treat Minor- Fall 2021 Injury Clinic

I hereby give my permission and authorization for the following representative of the school district or organization below (person must be over the age of 18) to obtain medical care for my child. I also authorize the providers of Texas Orthopaedic Associates to discuss or disclose information regarding any matters related to my child's appointment and test results or medical care to those listed below. I authorize Texas Orthopaedic Associates to use additional contact information below to discuss or disclose information regarding any matters relating to this appointment only, test results and/or medical care provided to the school district or the organization and its representatives.

School District/ Organization: _____

Representatives Name: _____ Patient's DOB: _____

Representatives Role in Organization: _____ Phone Number: _____