CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION

Patient Name (Printed)	Social Security Number	Company

The undersigned consents to any treatment or procedures rendered the patient by Coastal Orthopedics and Sports Medicine under the general and specific instructions of the physician. It is further understood that Coastal Orthopedics and Sports Medicine is authorized to carry out all instructions of the patient's doctor and that Coastal Orthopedics and Sports Medicine is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Coastal Orthopedics and Sports Medicine to provide me with the treatment, and to perform any rocedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

The undersigned certifies that (s)he has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

- **MEDICARE LIFETIME SIGNATURE AUTHORIZATION and CERTIFICATION FOR PAYMENT**

I certify that the information given by me in applying for payment under Title XVII 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 the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the group medical practice, furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also request that this authorization apply to all other insurance.

- **MEDIGAP INSURANCE AUTHORIZATION**

I request that payment of authorized Medigap benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to [*see copy of Medigap card*] any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

- **OTHER INSURANCE AUTHORIZATION**

I request that payment of authorized benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to (*see copy of card)* any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guarantor ______________________ Date ______________________

Signature of Witness ______________________ Printed Name of Witness ______________________

Consent for Treatment of a Minor

I hereby authorize Coastal Orthopedics and Sports Medicine to administer treatment as they so deem necessary to my son/daughter,

Signature of Parent or Guardian ______________________ Date ______________________

Printed Name of Parent or Guardian ______________________

Signature of Witness ______________________ Printed Name of Witness ______________________