CONSENT TO TREATMENT

Patient Name _____ Date of Birth: ____/____/____

On behalf of myself or other patient named above, CONSENT TO TREAT I hereby give my permission to ORTHOPAEDIC SPINE INSTITUTE (referred to as "OSI" in this form) for the evaluation and treatment of the presented medical condition (herein referred to as "health care services"). I am requesting that health care services be provided to me (or the patient named above) at OSI. I voluntarily consent to all treatment and health care services that the caregivers at OSI consider to be necessary for me (or the patient named above). These services may include diagnostic, therapeutic, and imaging services.

I am aware that the practice of medicine and surgery are not exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

FINANCIAL RESPONSIBILITY Subject to applicable law and the terms and conditions of any applicable contract between OSI and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay OSI for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to me (or the abovenamed patient), I agree to be financially responsible and obligated to pay OSI for the patient balances due.

ASSIGNMENT OF BENEFIT In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to OSI all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding OSI's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by OSI to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with OSI for my insurance to be billed and as such I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide OSI with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

CONSENT TO RETRIEVE MEDICAL INFORMATION As a patient of OSI, I authorize OSI to retrieve and use my medication history from an electronic prescriptions network. This is an electronic method for OSI to access patient prescription benefit information and patient medication history. OSI can only retrieve medication history from pharmacies posting to the Illinois pharmacy monitoring program. Utilizing this method is the best way to obtain the most up to date information so that your healthcare provider can deliver the best care to you.

NOTICE OF PATIENT GUIDELINES: I understand that taking photographs and/or recording of any type is prohibited unless express permission is granted by OSI.

NOTICE OF PRIVACY PRACTICE: I have received a copy of the OSI Notice of Privacy Practices. The Notice of Privacy Practices explains how OSI may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let OSI use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by OSI, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent OSI or provide assistance to OSI for the purposes of securing payment from all parties who

are potentially liable for payment for my (or the above-named patient's) health care. I can revoke my consent in writing at any time except to the extent that OSI has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to OSI or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or pre-recorded voices, automatic telephone dialing systems, or any other computer-aided technologies from OSI and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from OSI or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

Patient / Legal Guardian Signature	Print Name
Relationship to Patient (if other than self)	Signature Date
Witness Signature	Witness Signature Date