AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees to the following:

1. I authorize payment of medical benefits to the physician(s) rendering service(s).
2. I agree and acknowledge that my signature on the document authorizes my physician(s) to submit claims for benefit, services rendered, or services to be rendered without obtaining my signature on every claim submitted for myself and/or dependant(s). I will be bound by this signature as though the undersigned had personally signed the particular claim.
3. I will pay to the physician(s) any balance due for serviced rendered. I understand that if payment is not made on my behalf by my (insurer, legal representative, or workmen's compensation insurance) I will be responsible for any outstanding balance.

Patient Signature/Date

PATIENT FALL PREVENTION:

Everyone tries to be careful to avoid falls. But when you are sick or injured, you may be prone to accidental injury. Please take a few moments to complete the following questionnaire.

Have you fallen as an adult? _____ Yes _____No If Yes, When? _____

Have you noticed any problems with walking and balance? _____ Yes _____ No

Do you have uncorrected hearing or vision problems? _____ Yes _____ No

Do you need help with getting out of bed/chairs, using the bathroom or bathing?

_____ Yes _____ No

Please check any aid you currently use:

□ Cane □ Walker □ Wheelchair □ Bathroom Rail □Hearing Aid

□ Other, Please Specify: _____

□ Because you answered "Yes" to any one of the questions or you use an assistive device, you are at risk for falling, and therefore have received home safety tips. I understand that fall prevention in the home can only be successful if patients and their families become partners in fall prevention. After reviewing the material please contact the office for any questions.

□ Because you answered "No" to all of the questions and do not use an assistive device, you have a low risk for falling at this time. Since your fall risk is directly related to your overall condition, we will periodically ask you to answer these questions. Should your condition change, please let us know.

CONSENT TO TREATMENT:

1. I am presenting myself as an Outpatient and I voluntarily consent to the rendering of care and treatment as may be ordered by my health care provider, associate or assistant. This includes medical treatment such as X-ray, Examinations, Laboratory Tests, and minor procedures my physician/provider may order.
2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this office.
3. I understand that I have the **RIGHT TO CONSENT** or **REFUSE CONSENT**, to any proposed procedure or therapeutic course. I also understand that it is customary, absent emergency or extraordinary circumstances, that no procedure which pose a material risk of harm are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional to my satisfaction.
4. I have had the opportunity to discuss this form, and I understand its contents and what it means. I verify that I have seen and/or received a copy of The Patient Rights and Responsibilities and understand its contents.

PATIENT SIGNATURE / SIGNATURE OF AUTHORIZED PATIENT REPRESENTATIVE DATE

WITNESS: _____ DATE: _____