JACOB CENTER FOR ADVANCED ORTHOPAEDICS

Jesu Jacob, D.O., P.C.

Orthopaedic Surgery

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Authorization to Release Information

I hereby authorize Dr. Jacob and all medical affiliates to release any health care information necessary to facilitate processing of claims, audit of payments and routine professional medical communication with my referring and/or primary care physicians and any necessary medical/surgical facilities. Jesu Jacob, D.O., P.C. maintains a record of health care services provided to you. You may request to see and obtain copies of that record at any time. Jesu Jacob, D.O.,P.C. will otherwise not disclose your records or personal health information to others unless you direct us in writing or unless required by law.

Medical Consent

I give my consent for all routine, usual and customary tests, exams and procedures as prescribed by Dr. Jacob and/or any affiliates of Jesu Jacob, D.O.,P.C. for myself or my minor child or as legal guardian.

Assignment of Insurance Benefits

I hereby authorize Jesu Jacob, D.O.,P.C. to request on my behalf and to collect directly all public and private insurance coverage due for products and services supplied byJesu Jacob, D.O.,P.C. In the event that benefits are paid directly to me, I will endorse to Jesu Jacob,D.O.,P.C. all checks for such payments and hand them over immediately.

Financial Responsibility

I acknowledge that I am financially responsible for all charges. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits or procedures, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and interest and collection charges for overdue payments. I agree to a collection charge of 40% of my unpaid balance at time of collection determination. I hereby authorize Jesu Jacob,D.O.,P.C. to release information necessary to secure payment of benefits or fees.

Signature of Patient/ Guarantor Printed Name of Patient/Guarantor Date