POWDER RIVER ORTHOPEDICS & SPINE
508 STOCKTRAIL AVE, SUITE A
GILLETTE, WY 82716
P: 307-686-1413

Campbell County Clinics – **POWDER RIVER ORTHOPEDICS & SPINE (PROS)**

CONSENT FOR TREATMENT/PATIENT AUTHORIZATION

THIS DOCUMENT SUMMARIZES THE AGREEMENT BETWEEN CAMPBELL COUNTY MEDICAL GROUP, DBA CAMPBELL COUNTY CLINICS, AND EACH PATIENT WHO ACCEPTS MEDICAL CARE AND TREATMENT AT CAMPBELL COUNTY HEALTH FACILITIES.

CONSENT FOR MEDICAL TREATMENT: I understand and acknowledge that in presenting myself voluntarily for treatment, I authorize and consent to such examinations, tests, medications, photograph documentation and other medical procedures at Campbell County Clinics, which may be advised and recommended by my attending physician, provider or surgeon. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations or treatments at the Campbell County Clinics. I hereby authorize the Campbell County Clinics to retain, preserve or dispose of any specimens or tissues taken from my body during my outpatient services. I understand that my care may be observed or provided by a health care professional in training under supervision.

FINANCIAL AGREEMENT: By accepting the medical services provided to me as a patient, I agree to be financially responsible for the charges billed by Campbell County Clinics or its affiliates for those services. I hereby authorize Campbell County Clinics to release medical information necessary to submit insurance claims and/or financial information acquired in the course of my examination and treatment in connection with this visit for the purpose of insurance and/or Medicare/Medicaid benefit payments.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payments directly to the above named facility of the insurance for these services**. I hereby authorize PROS to file to my health insurance should my liability, mva , worker's compensation or any other primary insurance carrier deny my claims for any non-covered services. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE CAMPBELL COUNTY CLINICS FOR CHARGES NOT COVERED BY INSURANCE OR DESIGNATED THIRD PARTY PAYEE.** If I (we) fail to pay, I (we) agree, in addition, to pay all costs of collection and reasonable attorney fees. I have been notified of the credit terms and I authorize any holder of information regarding the financial status of collection of my account, including employment verification, to release said information to Campbell County Clinics.

THE UNDERSIGNED CERTIFIES THAT HAVING READ THE FORGOING, RECEIVING A COPY THEREOF, IF REQUESTED, AND IS THE PATIENT OR DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

PLEASE COMPLETE BELOW

PRINT Patient Name _____ ***Date***_____ ***Time***_____

SIGNATURE of Patient/Representative/Guardian _____***-Relationship***_____

IF WORKER'S COMPENSATION-PLEASE COMPLETE BELOW

WORK-RELATED INJURY: I hereby claim that this visit is because of a WORK-RELATED INJURY and I authorize Campbell County Medical Group, DBA Campbell County Clinics, to release any and all information concerning this visit to my employer.

Patient_____/_____/_____
Signature ***Date*** ***Time***

Witness/Parent_____/_____/_____
Signature Represents Witness for Entire Document ***Date*** ***Time***