
# PARAGON SPORTS MEDICINE, LLC

## PATIENT ACKNOWLEDGEMENT

By signing the document below and by initialing each paragraph, the patient or responsible party listed above acknowledges they have read and understood the following:

### PAYMENT RESPONSIBILITY

_____ Payment for office services or the co-payments and/or the co-insurance is due when service is rendered. Payment for medical services is between Paragon Sports Medicine and the patient/responsible party. Therefore, Paragon Sports Medicine cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness, (4) liability claim, (5) claim where patient is or will be represented by an attorney, and/or (5) claim to be settled in a court of law.

### INSURANCE LIMITATIONS

_____ Some insurance carriers require a written referral from a Primary Care Physician in advance of service provided by Paragon Sports Medicine. Patients or person responsible for the patient must (1) obtain any required physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles, and co-insurances. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. Paragon Sports Medicine will file a patient's insurance as a courtesy.

### ASSIGNMENT OF MEDICAL BENEFITS

_____ The patient or responsible party certifies that information provided relative to injury, illness, and insurance coverage is both true and correct. By signing this form the patient or responsible party authorizes payment of insurance benefits or proceeds from any liability claim or legal court settlement to be assigned to Paragon Sports Medicine to the extent that their charges are paid in full.

### AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

### CONSENT TO TREAT

_____ I hereby voluntarily consent to my treatment at Paragon Sports Medicine and authorize such treatments, examinations, and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending/covering physician.

Patient Name _____

Signature of Patient/Responsible Party _____ Date _____


PARAGON
Sports Medicine