SOUTHERN ILLINOIS ORTHOPEDIC CENTER, L.L.C. CONSENT FORM

AUTHORIZATION FOR SURGERY: I hereby authorize Doctor _____ and any assistant to perform a

_____

_____On _____(patient).

I recognize that conditions may necessitate additional or different procedures than those specifically set out above. I thereby authorize and request above named doctors or designees to perform such procedures. I consent to the administration of whatever anesthetics may be necessary or desirable. I consent to the study and disposition of body tissue removed in the procedure. I have been informed of certain risks in all procedures and this procedure in particular. I have been informed of the benefits of this procedure as well as other alternatives available.

AUTHORIZED OBSERVERS: I consent to the presence of individual observers authorized by my physician.

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS TO OTHER HEALTH CARE PROVIDERS: I, the undersigned, hereby authorize Southern Illinois Orthopedic Center, L.L.C. to release such information, including, but not limited to, my patient records to another health care provider if Southern Illinois Orthopedic Center, L.L.C. reasonably believes the purpose for releasing such information is for my continued or future care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the Southern Illinois Orthopedic Center, L.L.C. for benefits otherwise payable to me. I also authorize payment of benefits directly to the Southern Illinois Orthopedic Center, L.L.C. anesthetists. I understand that I am financially responsible to Southern Illinois Orthopedic Center, L.L.C. and my physicians for charges not covered by my insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the Southern Illinois Orthopedic Center, L.L.C. to release such information as may be necessary for the completion of my insurance claim forms.

COUNTY ASSISTANCE CONSENT: I authorize the Southern Illinois Orthopedic Center, L.L.C. and any holder of medical or other information about me or members of my household to release to my county of residence any information needed for this or a related County Assistance Claim. I request that payment of authorized benefits be made on my behalf.

MEDICARE CONSENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

BILLING AND CREDIT POLICY: All patients accounts will be considered due upon receipt of your itemized bill. As a courtesy to you, the Business Office will process your insurance if proper information is provided. You will be billed on the current balance of your account regardless of the insurance claim status.

ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS: I consent to the administration of blood or blood products if my medical condition warrants the administration of such products.

TESTING FOR HIV (AIDS) AND/OR HEPATITIS: I consent to testing for HIV (AIDS) and/or Hepatitis should a healthcare worker have accidental exposure to my blood or other body substance, or in the event testing is directed by my physician.

PHOTOGRAPHY/VIDEO RECORDING: I consent to photographing or video recording of the operation or procedures to be performed for scientific or educational purposes, provided my identity is not revealed by the picture or by descriptive texts accompanying them.

ATTENTION: The Southern Orthopedic Associates physicians and Southern Illinois Healthcare have an ownership interest in the Southern Illinois Orthopedic Center, L.L.C.

I understand that unless otherwise advised by the staff of the Southern Illinois Orthopedic Center, L.L.C., I should not operate a motor vehicle or machinery or potentially dangerous appliances, drink alcoholic beverages or make critical decisions for 24 hours following discharge. I understand that a responsible adult must accompany me when I am discharged.

I certify that I have read and hereby authorize the above.

Patient: _____ Patient's Representative: _____

Witness: _____ Relationship to Patient: _____

Date: _____ Time: _____

Physician Signature: