PATIENT AGREEMENT

I. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES:

In consideration of services rendered by Richard S. Obedian, M.D., PLLC to the undersigned patient, the undersigned promise(s) to pay to Richard S. Obedian, M.D., PLLC any co-payment, co-insurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan. In case of denial or termination of benefits, or in the event I fail to inform you of any changes in my insurance coverage, I, the undersigned understand that I am responsible for payment in full for services rendered.
In case of denial from No-Fault, the Workers' compensation Board, Workers' Compensation Carrier or termination of my orthopedic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

II. ASSIGNMENT OF BENEFIT PROCEEDS:

I hereby assign to Richard S. Obedian, M.D., PLLC all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payer, No-Fault, Workers' Compensation policy, government agencies, or those who are financially liable for my medical care.

III. AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize Richard S. Obedian, M.D., PLLC to release to my insurer/HMO/third-party payer, government agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of pre-certification/prior approval purposes.
It is, however, understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

IV. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION {PHI}:

I hereby authorize Richard S. Obedian, M.D., PLLC to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI for Richard S. Obedian, M.D., PLLC and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from Richard S. Obedian, M.D., PLLC I voluntarily sign this authorization. I have been provided the opportunity to review the PHI agreement in full.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Phone: ____________________
- ☐ Work Phone: ____________________
- ☐ Other Phone: ____________________
- ☐ Email____________________________
- ☐ I authorize you to leave a detailed message at my home or work phone number.
- ☐ I authorize you to contact or speak to the following individuals regarding my care:

____
____

ADDITIONAL AUTHORIZATION WILL BE NEEDED FOR RELEASE OF MEDICAL RECORDS

Print	Sign	Date