Place Label Here

CONSENT FOR MEDICAL TREATMENT: I hereby authorize the personnel of Multi-Specialty HealthCare (MSHC), Harford County Ambulatory Surgery Center (HCASC), Baltimore Work Rehab (BWR), MDDC HealthCare, MED LLC, Rx, and Multi-Specialty HealthCare MRI and members of its medical staff (our medical staff consists of medical doctors, chiropractors, physician assistants and nurse practioners) to render to the patient whose name appears on this form care as any of these individuals deem necessary and appropriate.

PHYSICIAN ASSISTANTS/SUPERVISING PHYSICIANS: I understand that when treatment is rendered to me by a physician assistant, the physician assistant's supervising physician will be involved in my care, including the prescribing and dispensing of medications.

AUTHORIZATION TO RELEASE/ACCESS INFORMATION: I hereby authorize Advanced Medical Management (AMM) and Affiliates to release, via hard copy or electronically, my diagnosis and other medical information to my attorney; also to release copies of any other medical reports we procure from other sources, regarding my current injury as well as any prior medical records, as requested. Upon release to the my attorney, AMM and Affiliates is not responsible for the use or release of this information pursuant to this authorization. I understand that the providers of AMM and Affiliates may access my medication history by using Health Information Exchange (HIE) & the Prescription Drug Monitoring Program (PDMP). With the exception of the controlled substance clinical data reported to the PDMP, this authorization may be revoked by you at any time by submitting a request in writing to your treating office.

STATEMENT OF FINANCIAL POLICY: The providers and staff of AMM and Affiliates are very concerned about the cost of your healthcare. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise for your care. Our fees are comparable with the fees for similar specialties within the Baltimore/Washington metropolitan area. We use many sources to determine the appropriateness of our fees. AMM and Affiliates will submit your claim to your insurance company on your behalf; however you are ultimately responsible for the service you receive.

ASSIGNMENT OF BENEFITS /GUARANTEE OF PAYMENT: I hereby authorize direct payment to AMM and Affiliates of any insurance, personal injury, or other benefits otherwise payable to me for any services rendered. I hereby further give a lien on my case to AMM and Affiliates against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself as a result of the injuries I have been treated or injuries in connection there within. I authorize and direct my attorney, to withhold any sums from any settlement, judgment or verdict as may be necessary to adequately protect AMM and Affiliates and to pay directly to AMM and Affiliates for services rendered to me. I acknowledge that, if AMM and Affiliates allow me to delay payment in anticipation of third-party reimbursement, including any funds procured from a settlement, such forbearance is a courtesy only, and such courtesy may be withdrawn at any time upon notice to me. If AMM and Affiliates do not offer me a delayed payment courtesy, then I understand that payment by me for services rendered are payable in full at the time of service. If a delayed payment courtesy is offered to me, but subsequently withdrawn, then I understand that payment by me for all services rendered will become due upon demand by MSHC and Affiliates I grant AMM and Affiliates a power of attorney to collect these sums on my behalf. I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event that another attorney is substituted in the matter, the new attorney will honor the lien as inherent to the settlement, judgment, or verdict and enforceable upon the case as if it were executed by him. I agree to notify AMM and Affiliates in writing if I change or substitute my attorney. I understand that I am financially responsible for all medication once I leave the office, even if I decide I do not want the medication, MED LLC, Rx will not issue a refund for unused or unwanted medications. I further acknowledge my responsibility for any health insurance deductible, coinsurance, or other sum not paid by an insurance carrier or any other third-party for any reason, payable upon demand by MSHC and Affiliates. I understand that AMM and Affiliates may discontinue my treatment if timely payment of any sum owed by me is not made when requested. I acknowledge that a late fee of one-half percent (.5%) per month may be charged to unpaid balances remaining after thirty (30) days from the date payment is due. In the event that the account is referred to collections, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance. In the event that any insurance company which is obligated by law or contract to make payment for my medical services refuses to make such payments, in whole or in part, I hereby assign AMM and affiliates my rights to any cause of action that exists in my favor against any such insurance company to pursue any action in my name and to settle or otherwise resolve any such action as AMM and affilaites deems fit.

PRESCRIPTION SERVICES: As the patient, you may obtain medications here, if a pharmacy is not conveniently located to you. Please inform your provider of your preference when medications are discussed during your visit.

Place Label Here

BENEFICIAL INTEREST NOTICE: During the course of your treatment at Multi-Specialty HealthCare you may need diagnostic tests to give your treating provider important information about your illness/injury. Subsequently, additional treatment or surgery may be required. We have facilities to provide some of these additional services. You may choose to have the services performed at our centers or anywhere you like. Please be advised that Dr. Constantine Misoul and Dr. Lawrence Rubin have a beneficial interest or compensation arrangements with Multi-Specialty HealthCare MRI, MED LLC, Harford County Ambulatory Surgery Center and Baltimore Work Rehab.

PHYSICIAN/FACILITY CHARGES: I understand that in addition to any bills I may receive pertaining to physcian's professional fees; I will also receive a separate facility bill.

OBTAINING COPIES OF MRI: Should you need to obtain a copy of your MRI, please call the facility where the MRI was preformed. Please allow 48 hours for the copy to be produced.

PERSONAL VALUABLES: Patients are encouraged to leave all money and valuables at home. AMM and Affiliates shall not be responsible for the loss of or damage to any personal property brought into AMM and Affiliates inclusive of glasses, dentures and jewelry.

TELEPHONE MESSAGES: By signing this document, I give permission to AMM and Affiliates to leave messages regarding my appointments on my answering machine or with a responsible person answering my home phone.

USE OF ELECTRONIC DEVICES: To ensure confidentialty and privacy the use of all electronic devices is prohibited at any location within our offices. These devices include, but are not limited to, cell phones, portable tablets or any other type of recording device.

SUPPLEMENTAL INCOME INSURANCE FORMS: During the time of your disability, you may have insurance forms you will need us to complete, in order to get certain bills paid. These bills could include your mortgage payment, car payment, credit cards, etc. As a courtesy to you, our patient, we will be happy to complete these forms for you. We will fill out the first of these forms at no cost to you. After the first form there will be a cost of $11.00 per form, which is your responsibility, payable by credit card. You must complete as much of the form as you can, and allow us five (5) business days to complete. We will call you when the form is ready and you may stop in the office to pick up the completed form. If you want the form mailed to you, you must provide us with a self -addressed, stamped envelope. We will return the form to you as soon as it is completed.

PATIENT RIGHTS AND RESPONSIBILITIES/ NOTICE OF PRIVACY PRACTICES: I acknowledge that I am in receipt of AMM and Affiliates Patient Rights and Responsibilities and Notice of Privacy Practices.

SCHEDULED APPOINTMENTS: Please make every effort to arrive on time for your scheduled appointments. If you should arrive late for your appointment, we will make every attempt to see you, but our staff will care for patients that arrive on time, prior to caring for you.

I CERTIFY THAT 1.) I UNDERSTAND THE CONTENTS OF THIS FORM AND 2.) ALL INFORMATION GIVEN TO AMM AND AFFILIATES INCLUSIVE OF INSURANCE INFORMATION IS ACCURATE AND CORRECT. A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

_____ _____

Signature (Seal)** Date

_____ _____

Patient Name (Please Print) Witness

_____ _____

Authorized Person's Signature Relationship to Patient

Reason patient unable to sign (check one): Minor [] Condition []

** Signed under SEAL is a "specialty", which requires a cause of action be filed within twelve years after the cause of action accrues.