Christopher M. Meckel, MD
Board-certified orthopedic surgeon, Fellowship-trained in sports medicine & joint replacement

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1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform Monterey Spine and Monterey Joint or any of the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name

Signature of responsible party   Date

2 Consent for minor

I grant Monterey Spine and Monterey Joint and the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature   Date

Relationship to patient

3 Notice of privacy practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature   Date

If not signed by the patient, please indicate the relationship between the signee and the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

For office use only

Date received

Copyment   ☐ Yes ☐ No Authorization required

Processed by

☐ Yes ☐ No

Practice follow-up   Date of follow-up

Complete the following only if the patient refuses to sign the acknowledgement

Efforts to obtain

Reason for refusal