Patient Name: _____
Patient DOB: _____

JACKSON ORTHOPAEDIC CLINIC
GENERAL CONSENT FOR TREATMENT

Consent for Treatment: The undersigned authorizes and consents to JACKSON ORTHOPAEDIC CLINIC and its physicians furnishing medical and surgical treatment that the Patient's· physicians consider necessary and proper in the treatment of the Patient. This treatment may require diagnostic procedures, including but not limited to, laboratory tests, drawing blood for those tests, x-ray/imaging, and electrocardiograms.

Pay Insurance Benefits: The undersigned assigns payment directly to JACKSON ORTHOPAEDIC CLINIC for all insurance and similar benefits otherwise payable to the Patient by virtue of medical treatment provided by JACKSON ORTHOPAEDIC CLINIC, but not to exceed JACKSON ORTHOPAEDIC CLINIC regular charges for medical treatment. The undersigned understands the Patient is financially responsible for charges not covered by insurance, and the undersigned agrees that the Patient shall be responsible for all charges incurred, regardless of the status of medical insurance or similar benefits.

Medical Education*: I agree that care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty in accordance with organizational policies.

Photography and Other Recordings*: I consent to photographs, audio, and video recordings, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in exam room.

Authorization for Healthcare-Related Calls, Texts and E-mails: I, the undersigned, hereby authorize and consent to employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide. This consent and authorization will apply to text messages sent to the wireless numbers I provide and to e-mails using any e-mail address that I provide. I understand that texting or emailing to the numbers and addresses I provide may not be secure. This consent and authorization will apply to the current visit and any future visits. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the following address:

JACKSON ORTHOPAEDIC CLINIC
308 CORPORATE DR
RIDGELAND, MS 39157

Specimens: Further, I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention, or medical treatment.

Devices: I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

Patient Name: _____
Patient DOB: _____

Payment Terms: The undersigned understands that payment is due in full on the date of treatment for all services provided and the undersigned agrees to pay all charges for the Patient. JACKSON ORTHOPAEDIC CLINIC does not issue refunds to patients with a credit balance of less than $5.00 and will not issue invoices for balances owed of less than $5.00. After 90 days, these balances will be written off by JACKSON ORTHOPAEDIC CLINIC and any credit balances of the patient will be retained by JACKSON ORTHOPAEDIC CLINIC. The undersigned understands and agrees to JACKSON ORTHOPAEDIC CLINIC policy regarding credit balances of less than $5.00.

Prescription History: The undersigned authorizes JACKSON ORTHOPAEDIC CLINIC Medical Clinics obtaining the Patient's prescription drug history from pharmacy networks for safer patient outcomes.

Release of Medical Information: The undersigned authorizes JACKSON ORTHOPAEDIC CLINIC Medical Clinics and its physicians providing to the Patient's Insurance companies and· outpatient benefit programs the Patient's health information as needed to process insurance claims. The undersigned understands JACKSON ORTHOPAEDIC CLINIC participates in various health programs with insurance carriers and may be required to submit the Patient's health.
information to the Patient's insurance carriers or outpatient benefit programs. The undersigned authorizes JACKSON ORTHOPAEDIC CLINIC providing the requested information related to the health program to the Patient's insurance carriers or outpatient benefit programs.

Release to Work or School: If requested by the Patient's work or school, the undersigned authorizes JACKSON ORTHOPAEDIC CLINIC providing the Patient's work or school a written excuse.

Consent for Retirement of X-Ray Film/Graphic Data: The undersigned authorizes and consents to JACKSON ORTHOPAEDIC CLINIC retiring the Patient's x-ray films and any other graphic data, four (4) years after they are generated or created if the written and signed findings of a radiologist or other professional who has Interpreted the x-ray film or graphic data is maintained in the Patient's medical record.

By signing below, I acknowledge that I have read this form, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have.

Patient Name (print): _____

Patient Signature: _____

Date: _____ **Time:** _____

Authorized Person for Consent Name (print): _____

Authorized Person for Consent Signature: _____

Date: _____ **Time:** _____