Sports Concussion Institute (SCI) and Affiliated Clinics

Conditions of Service

1. Consent to Medical Procedures

The patient identified below consents to the procedures which may be performed during this outpatient visit by a physician, neuropsychologist, or other healthcare professional. Procedures include but are not limited to physical exams, computerized and pencil/paper neuropsychological screening and evaluation tests, cognitive rehabilitation services and referrals for laboratory and imaging procedures.

2. Teaching Program

Under the supervision of the attending physician or neuropsychologist, interns, post graduate fellows and physician assistants may participate in the care of the patients as part of the education program of SCI.

3. Financial Obligations

I further understand that I am responsible to SCI for all charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by SCI, I understand that I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.

4. Assignment of Insurance or Health Plan Benefits

The undersigned assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to SCI of all insurance and plan benefits otherwise payable to or on behalf of the patient for the outpatient services. It is agreed that payment to SCI pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

5. Medicare Patient's Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I understand I am responsible for any remaining balance not covered by other insurance.

6. Release of Information

SCI will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the Institute is permitted or required by law to release information.

Is this injury potentially going to be in litigation? Yes ____ No ____

I have read and understand paragraph 6, and have answered the question above to the best of my knowledge. Patient or Patient Guardian initials: _____

7. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (paragraph3) and Assignment of Insurance of Health Plan Benefits (paragraph 4) set forth above.

_____ _____ _____

Date Financially Responsible Party Witness

Translator: I have accurately and completely read the foregoing document to _____ (name of patient/person legally authorized to give consent) in _____, the patient's or patients representative's primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____ _____

Date/Time Patient/Parent/Responsible Party Translator

_____ _____

If other than patient, indicate relationship Witness