



AUTHORIZATION

I. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to **ADVANCED CENTERS FOR ORTHOPAEDIC AND SPORTS MEDICINE**, (the “Doctors”) of the surgical, medical, and physical therapy benefits, if any, otherwise payable to me for their services as described below, but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charges not covered by this authorization.

II. AUTHORIZATION FOR TREATMENT AND DISCLOSURE: I hereby authorize **ADVANCED CENTERS FOR ORTHOPAEDIC AND SPORTS MEDICINE** to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of me, or the child/spouse of the undersigned. Further, I authorize **ADVANCED CENTERS FOR ORTHOPAEDIC AND SPORTS MEDICINE** to disclose complete information concerning records regarding the condition or accident of me / my child / _____ to any collateral source or insurance company who will pay part or all of said medical bill. I hereby waive on behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information.

III. RESPONSIBILITY: I understand that all bills for the Doctors’ services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest or payor including any deposition costs, court appearance fees and consultation fees should same be incurred by me or anyone representing me.

IV. INTEREST AND COLLECTION COSTS: I agree to pay a finance charge as posted by the Doctors for services unpaid in excess of sixty (60) days. In the event the Doctors refer my bill to their attorney for collection, then I agree to pay the pre-judgment interest at the rate of One and One-Half percent (1½%) per month on all balances due over sixty (60) days from the date the services were rendered, reasonable attorney’s fees, court costs and service of process costs to said doctors in addition to the amount owed for services rendered.

V. WAIVER OF LIMITATION: I further understand that my matter, for which I am receiving treatment, may take in excess of three (3) years to conclude. I, therefore, agree that I shall not raise or use the Statute of Limitations as a defense to any cause of action that the Doctors may bring against me for the payment of any monies owed to them as I hereby waive such defense.

V. CONSENT TO JURISDICTION: I hereby agree that whatever agreement is made between the patient and the Doctors, said agreement is made in, governed by, to be performed in, and shall be construed in accordance with the laws of the State of Maryland. I further consent and submit to the jurisdiction of the Courts of the State of Maryland and expressly agree to such forum for the bringing of any suit, action or other proceeding arising out of my obligations hereunder, and expressly waive any objection to venue in any such Courts, and waive any right to a trial by jury so that trial shall be by and only by the Court. It is further agreed and understood that the doctors are located within the venue of the State of Maryland.

DATE

RELATIONSHIP: _____