Consent for Provider Services

Name: _____
(Last) (First) (MI)

DOB: _____

1. **Annual Consent for services**: I consent to the services that may be performed by an Innovative Sports Medicine ("ISM") physician/provider. I understand I can withdraw my consent at any time.

2. **Financial Agreement:** I agree to accept financial responsibility for all services provided to me by ISM. I also agree to promptly pay all provider bills, in accordance with the applicable rates and terms. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the legal rate.

3. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform ISM of any changes as soon as possible.

Date: _____ Signature: _____

If signed by other than patient, indicate relationship: _____

Witness: _____

Mailing address_____

_____

Phone: _____ Cell:_____

Email (optional): _____

Medicare Patients:

Have you met your deductible for the year? Yes ☐ No ☐