I. NOTICE OF FINANCIAL OR INVESTMENT RELATIONSHIP

In order to provide you with the most comprehensive quality care, you may be referred to a facility in which Knoxville Orthopaedic Clinic (KOC) physicians may have an ownership interest. This document serves as notice to you of the financial investments or relationships of the physicians of KOC. KOC physicians have investment interests in the following: Fort Sanders West Outpatient Surgery Center, Advanced Family Surgery Center, Knoxville Orthopedic Surgery Center, KOC Therapy, KOC Imaging, and KOC Orthotics. In addition, your physician may have financial relationships with orthopedic manufacturing companies which produce surgical implants and other orthopedic products that may be used in connection with your treatment.

You may request an alternative provider for your services (physical therapy, MRI, surgery centers). If you would like to seek your medical services elsewhere, please inform your physician and you will be referred to another comparable facility. We assure you that you will not be treated differently at KOC if you request an alternative provider. If you have any questions or concerns regarding the above notice or your treatment plan, your physician will be happy to discuss those with you. **Patient/Legal Representative Initials**:_____

II. AUTHORIZATION FOR TREATMENT AND FILING INSURANCE

I authorize consent for treatment, the release of any medical information necessary to process this claim, and authorize payment of medical benefits by my insurance, including but not limited to Medicare, Medigap, TN Care, Commercial, etc., to KOC for services provided. I authorize KOC, as part of my medical evaluation and treatment, to access my electronic medication history. I understand that I am financially responsible for the charges covered by this authorization and for collection expenses on unpaid balances**. Patient/Legal Representative Initials**: _____

III. PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, have been made aware of KOC's Notice of Privacy Practices that is on public display in the lobby and also available on its website (www.kocortho.com). I understand that I may request a paper copy of the Notice of Privacy Practices at this location.

Designated Representatives: The following people may call to ask and/or receive medical information for and about me as well as sign for prescriptions that are picked up on my behalf.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may leave messages containing my medical information at the following phone number(s) without speaking to a person:

_____ _____

Patient/Legal Representative Initials: _____

I have read and understand Sections I, II and III above.

Patient/Legal Representative Signature_____ Date: _____

CONSENT FOR TREATMENT OF MINOR PATIENT (for non-emancipated minors less than 18 years old)

Patient Name: _____ Date of Birth: _____

By signing this form, I acknowledge that I am the parent/legal guardian of the above name child and I consent to KOC providing medical care, including, but not limited to physical exams, routine testing and other treatments. **NOTE: legal guardian must provide proof of guardianship (court order, power of attorney, etc.)**

I understand that I must be present for the initial office visit or the appointment will need to be rescheduled.

I understand and consent that my child may be seen for follow up appointments/treatments related to the initial office visit without me being present.

I agree with the above and give consent for the treatment of my minor child.

Parent/Legal Representative Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____