



Advanced Sports & Spine

Dr. Usman Ahmad

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General Consent for Medical Treatment

I voluntarily consent to the rendering of care, including treatments, administrations of anesthetics, and performing of diagnostics and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

Patient or Responsible Party Signature: _____

Assignment of Benefits

I hereby assign payment directly to the physician accepting this assignment of medical benefits applicable and otherwise payable to me but to exceed the physician regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any or all charges that the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to set physician by the insured or his/her family.

Lifetime authorization: Medicare/Medicaid patient certification – Patient certification authorization to release information and payment request: I certify that the information given by me in applying for payment under Title XVII/Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carries, any information needed for his/her Medicare/Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assigned the benefits payable for physician services. I understand that I am responsible for my health insurance deductible co-insurance.

Patient or Responsible Party Signature: _____