MEDICAL SERVICES CONTRACT

I hereby authorize Commonwealth Orthopaedic Specialist, Inc., to render medical services to myself (or child) and to release any information regarding my claim for benefits. I authorize payment directly to Commonwealth Orthopaedic Specialist, Inc. for the benefit otherwise payable to me under the terms of my insurance. Commonwealth Orthopaedic Specialist, Inc. may, but is not required, to file a claim with any and all policies of insurance. If the insurance company payment is not timely, I understand that it is my responsibility to pay any outstanding bill and pursue recovery of expenses with the insurance company. I understand that I am financially responsible for all the charges arising for treatment. I understand that I will be responsible for securing a referral for these services or for payment of these services if referral authorization is not received.

I hereby grant Commonwealth Orthopedic Specialist, Inc. an irrevocable lien on any and all med pay insurance I may have or may otherwise be a beneficiary to. In the event that my (or my child's) illness or injury has arisen out of an occurrence for which a third party is, or may be, responsible, I hereby grant Commonwealth Orthopaedic Specialist, Inc. an irrevocable lien on any recovery against said third party in an amount equal to the total of all sums due plus contract interest and attorney fees if the bill has been turned over to an attorney for collection. I acknowledge that there has been no representation or agreement by Commonwealth Orthopaedic Specialist, Inc. that it will withhold collection against me pending settlement of such a claim.

If the physician determines that I need a medical supply such as a brace or appliance to treat my problem, I understand that I have the option to obtain it from Commonwealth Orthopaedic Specialist, Inc. or from an outside supplier. If I choose to obtain the supply from Commonwealth Orthopaedic Specialist, Inc., a claim will be filed with my insurance company on my behalf. If an insurance payment is not received within 30 days, I understand that I will be responsible for payment in full immediately.

I agree to pay all attorney, or collection fees and court costs in addition to the total indebtedness incurred by Commonwealth Orthopaedic Specialist, Inc. If this indebtedness is not paid in full within sixty (60) days, I agree to pay a service charge of one and one-half percent (1 ½%) per month or a flat service charge of 35%, whichever is greater.

Patient acknowledges that the Doctor has determined that he/she is in the profession of providing quality medical care, not testifying as a witness in legal proceedings. Doctor has further that the Patient and all of Doctor's other patients are best served by Doctors express policy to decline, to the full extent permitted by law, to provide testimony as a witness in any type of legal proceeding. In the event that Doctor is compelled to testify he/she may, at his/her option, appear only as a witness to fact and, accordingly, interpret what is in the patient's records for the court. He/She, at his/her option, may not wish to offer an expert opinion. Patient consents to and agrees to abide by this policy. Patient further acknowledges that in the event Doctor is compelled to testify in connection with any such legal process, patient agrees to be responsible for payment of the fee prior to the Doctors testimony.

Commonwealth Orthopaedic Specialist, Inc. will provide patient with FMLA form completion as required by law, however a $15 (Fifteen dollar fee) will apply to all forms completed in excess of 1 (one) a month. The fee will be paid prior to completion. Please allow one week for form completion.

DATE_______________GUARANTOR SIGNATURE____