

SOUTH BEND ORTHOPAEDIC SPORTS MEDICINE & REHABILITATION
IMPORTANT NOTICE TO OUR PATIENTS

Dr. _____ has ownership of South Bend Orthopaedic Physical Therapy, South Bend Orthopaedic MRI, and Allied Physicians Surgery Center. The physician believes these facilities are appropriate settings for the medical care and services for which you are being referred. Nevertheless, the selection of a specific health care provider always rests with the patient, and you may choose to be referred to an alternate setting if you so desire.

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have been notified of the disclosure that the physician has financial interest in South Bend Orthopaedic Physical Therapy, South Bend Orthopaedic MRI, and Allied Physicians Surgery Center.

Patient or Personal Representative Signature*

Date

** If signed by Personal Representative, state relationship to Patient*