

LIFETIME AUTHORIZATION

- I. RELEASE OF INFORMATION** – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol, or drug related conditions and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
- II. PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.
- III. MEDICARE / MEDICAID** – Patient’s certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII /XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare / Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
- IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN’S OFFICE.** This assignment will remain in effect until revoked by me in writing,

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it’s my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and costs of collection.

DATE _____ PATIENT _____
Signature

SUBSCRIBER (if different from patient) _____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN’S OFFICE

ASSOCIATED ORTHOPAEDIC SPECIALISTS

PATIENT – CONTACT INFORMATION SHEET

I wish to be contacted in the following manner (**Check all that apply**):

_____ Home Telephone _____

_____ O.K. to leave message with detailed information

_____ Leave message with call back number only

_____ Work Telephone _____

_____ O. K. to leave message with detailed information

_____ Leave message with call back number only

_____ Cell Phone _____

_____ O.K. to leave message with detailed information

_____ Leave message with call back number only

_____ Written Communication

_____ O.K. to mail to home address

_____ O.K. to fax to this number _____

_____ Personal Contacts

_____ O.K. to release Protected Health Information to the following person(s)

Name: _____ Relationship _____

Name: _____ Relationship _____

I understand it is my responsibility to change this information should my circumstances change. I will notify Associated Orthopaedic Specialist in writing of any changes to the above.

Patients Name

Date

Print Name

Date of Birth