INSURANCE AUTHORIZATION AND ASSIGNMENT

PATIENT NAME_____
(PLEASE PRINT FULL NAME)

We accept assignment and bill all insurance carriers with who we are contracted participating providers. We follow the insurance company billing guidelines and referral process. All co-pays and deductibles are due at time of visit.

I,_____,hereby authorize Bay Area Orthopaedics and Sports Medicine to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance.

I also understand and agree that I accept responsibility for paying the physician's bill and any other bills relating to this case, including equipment and supplies regardless of insurance payments.

I,_____,understand that ultimately I am personally responsible for charges incurred for the collection of my account. These charges commence when my account has remained outstanding for 120 days or longer. A (1-1/2%) monthly interest charge will be assessed to any outstanding balance of 120 days or older. Should collection proceedings be necessary, a 15% service charge will be assessed to cover attorney fees. This applies to any denial of a Workman's Compensation claim or other pending litigation.

DATE_____ SIGNATURE_____