

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of my insurance benefits directly to LONGVIEW ORTHOPEDIC ASSOCIATES, PLLC. I understand that I am financially responsible for payment of all services regardless of any pending insurance claims. Insurance authorization, verification and co-payments are the responsibility of the member. I am also responsible for any legal costs incurred for the collection of my account.

I hereby authorize the release of any medical or other information necessary for the processing of the insurance benefits listed on the reverse page for medical and/or surgical services rendered.

Patient (Please Print) _____

Signature _____ Date _____

If a minor, by parent or guardian _____ Date _____

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information necessary for this or a related Medicare/Medigap/other insurance claim.

I permit a copy of this to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31U.S.C.3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature _____ Date _____

RECEIPT OF PRIVACY NOTICE

I acknowledge receipt of the LONGVIEW ORTHOPEDIC ASSOCIATES' Notice of Privacy Practices.

Signature _____ Date _____