

WORKERS COMPENSATION INFORMATION (if applicable)

W/C Carrier Name: _____ W/C Claim Number: _____
Contact Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: () _____

ATTORNEY INFORMATION (if applicable)

Attorney Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: () _____

AUTHORIZATION (required)

Check one that applies and sign below

- I am the patient and I voluntarily authorize the release of all my medical information, including any drug/alcohol, mental health and IV/AIDS information contained therein, for the purposes of determining insurance and other benefits payable. I also consent that the payment of authorized insurance benefits or Medicare benefits be made on my behalf directly to Northeast Orthopaedics for any medical or surgical services furnished.

- The patient is a minor and I authorize that treatment be given to him/her. I voluntarily authorize the release of his/her medical information, including any drug/alcohol, mental health and HIV/AIDS information contained therein, for the purpose of determining insurance and other benefits payable. I also consent that the payment of authorized insurance benefits be made on their behalf directly to Northeast Orthopaedics for any medical or surgical services furnished.

Signature: _____ Date: _____
Relationship (if patient is a minor) Parent Grandparent Guardian
 Other

FINANCIAL RESPONSIBILITY (required)

- I fully understand and agree that I am responsible for prompt payment of any portion of the charges not covered by insurance for services rendered to me, or said patient, by Northeast Orthopaedics. In case I default on payment, I also agree to pay all expenses connected with charges that are due.

- I fully understand and agree that if I am not aware of my insurance co-pay or percentage that I am responsible for, I will pay 20 % of the office charge as a down payment for services rendered.. Once insurance is filed and paid, I understand that I will either be billed for any patient amounts not covered or refunded any portion due to me.

- I fully understand and agree that if Northeast Orthopaedics is out-of-network for my insurance company, I am responsible for the full amount of the visit and will pay 50% of the charge of my initial appointment.

Signature: _____ Date: _____