

**BOCA RATON ORTHOPAEDIC GROUP
PATIENT CONSENT AND AUTHORIZATION**



Consent for Treatment: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedure. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). **Initial** _____

Assignment of Benefits: I hereby assign payment directly to the physician accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges for which the insurance carrier declines to pay. It is further agreed that any credit balance, resulting from payment of insurance or other services may be applied to any other accounts owed to said physician by the insured or his/her family. **Initial** _____

Release of Information: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to the family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. **Initial** _____

Medicare Certification – Payment Classification Authorization to Release Information and Payment Request:

I certify that the information given by me in applying for payment under Title XVIII and/ or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare, or third party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible and co-insurance. **Medicare only: Initial** _____

To Our PPO, HMO, POS & Open Access Patients: If we are a participating provider of your health plan, we will bill your plan directly, but you are required to pay your deductible, co-payment, and/or co-insurance at the time of service. If your insurance company requires a referral, it is your responsibility to furnish this referral at time of service. Failure to do this may require you to reschedule your appointment and/or accept full responsibility for payment. **Initial** _____

To Our Patients With No Insurance: All charges are due and payable in full at time of service. We accept most major credit cards, cash, or check. **Initial** _____

\$25 fee is charged for failure to cancel an appointment without a minimum 24-hour notice.

I have read the above **Consent and Authorization Policy** and agree to it by signing below.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____