

I authorize Orthopaedic Associates to treat and provide care as necessary.

Insurance Release

I hereby authorize the physician to release to any party responsible for payment any information acquired in the course of medical examination or treatment. A photostat of the authorization shall be considered as effective and valid as the original. I request that payment of authorized medicare benefits be made to me on my behalf to the party who accepts assignment, for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Authorization to Pay Benefits to Physicians

I hereby authorize the physician to receive direct payment for the amount due me in my pending claim for physician's services rendered. I understand that I am financially responsible for charges not covered by this authorization. A photostat of the authorization shall be considered as effective and valid as the original.

Notice of Privacy Policy (Upon Request)

I was given the opportunity to receive a copy of Orthopaedic Associates of Southeast Missouri's Notice of Privacy Practices.

I hereby authorize Orthopaedic Associates to discuss/release my medical financial information with/to the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient, Parent or Legal Guardian

Date

+++++
Medicare Patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopaedic Associates, P.C. for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services

Beneficiary Signature

Date