

Patient Name: Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, coinsurance and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Bowling Orthopaedics.

Signature of Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment / Authorization of Benefits**:

I, the undersigned, have insurance coverage and assign directly to Bowling Orthopaedics all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Bowling Orthopaedics to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Insured/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bowling Orthoapedics staff wants to be helpful in every way possible. We are happy to assist you with pre-certification and filing claims. Pre-certification must be received prior to your office visit. However, your insurance policy remains a contract between you and your carrier, not Bowling Orthopaedics and your carrier.

**Medicare Authorization**:

I request that payment of authorized benefits be made on my behalf to Bowling Orthopaedics for any services furnished to me by their practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

Please keep in mind:

* Final responsibility for payment of services rendered remains with the patient.
* Patients who do not have insurance coverage are required to pay for their visit at the time of service.
* Patients who do have insurance must pay their copayment at the time of the office visit.

By signing this form, I understand and agree to the above policies, including the policy regarding Medicare reimbursement.

Signature of Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy:**

* Payment for services rendered is due at the time of service
* If you have health insurance, Bowling Orthopaedics will file your insurance or you and apply any payments and adjustments to your account. However, you will remain responsible to pay your copayments, deductibles and co-insurance amounts at the time services are rendered.
* If you do not have health insurance, a minimum deposit of $ 150.00 is required prior to your initial visit. At the conclusion of the visit the balance will be due and payable. If the balance is not paid, Bowling Orhtoapedics expects a minimum monthly payment of $50.00 until the balance is paid in full.

By signing this form, I understand and agree to the above policies.

Signature of Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_