

The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION

150 KINGSLEY LANE • NORFOLK, VIRGINIA 23505 • Phone: 757.889.6580 • Fax: 757.889.6583

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN

I HEREBY CONSENT TO TREATMENT by the physicians of The Orthopaedic Center for Foot and Ankle Reconstruction, their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary.

I understand that payment (or co-payment) is expected at the time of service and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. I further understand if a balance exists on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid and paid in full at the time of settlement. **Should collection actions become necessary, I understand that I will be liable for any and all costs, including any attorney fees associated in collecting the unpaid balance owing on my account.**

I hereby authorize, the release of any information necessary for filing of any insurances and, direct payment to the physicians of The Orthopaedic Center for Foot and Ankle Reconstruction for any amounts due under my present policy(ies) or any policy that I may at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise The Orthopaedic Center for Foot and Ankle Reconstruction of any changes in insurance coverage.

I also authorize The Orthopaedic Center for Foot and Ankle Reconstruction to speak with and exchange information with other medical professionals regarding my medical condition. These medical professionals include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physician's assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practitioners.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Signed: _____
Patient or Responsible Party Date Witness

I understand that as a condition of my treatment at The Orthopaedic Center for Foot and Ankle Reconstruction, in the event litigation is required in this case, neither the physician nor the office staff will be available to appear in court. Conferences and/or depositions are scheduled.

Signed: _____
Patient or Responsible Party Date Witness

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Orthopaedic Center for Foot and Ankle Reconstruction for any services furnished to me by The Orthopaedic Center for Foot and Ankle Reconstruction. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or the benefits payable for related services.

Signed: _____
Patient or Responsible Party Date Witness

The Orthopaedic Center for Foot and Ankle Reconstruction files your insurance as a courtesy to you. If a co-payment or co-insurance is due from you, your insurance company, HMO, or managed care company requires us to collect this payment at the time of service. We accept cash, check, MasterCard, Visa and Visa debit cards.