



Orthopaedic
Specialists, P.A.

AUTHORIZATIONS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ORTHOPAEDIC SPECIALISTS FOR ALL BENEFITS PAYABLE TO MY DEPENDENTS OR ME. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION (TO THE APPROPRIATE BILLING AGENCY) NECESSARY TO PROCESS SUCH CLAIMS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCES OR CHARGES NOT COVERED BY MY INSURANCE.

I FURTHER UNDERSTAND THAT (SHOULD THIS ACCOUNT BECOME DELINQUENT) I WILL BE RESPONSIBLE FOR ALL ATTORNEY AND/OR COLLECTION FEES CHARGED IN AN ATTEMPT TO COLLECT ON THAT DEBT.

I UNDERSTAND THAT THERE IS A \$15.00 CHARGE FOR RETURNED CHECKS

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization/

Signed: _____ Date: _____