ROCKFORD ORTHOPEDIC

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LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Rockford Orthopedic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

MEDICARE

I certify that information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare/Other Insurance company benefits be made to me or on my behalf to ROA for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administrations or its intermediaries or carriers any information needed for this or related Medicare Claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand that I am responsible for notifying my insurance company to obtain authorization before service is provided if required by my insurance. I understand that if I do not pre-certify my treatment or obtain a referral prior to the first and all subsequent visits as required by my insurance, I may cause a reduction or loss of paid benefits to Rockford Orthopedic Associates I will be liable for that loss or reduction in paid benefits

I understand that I am financially responsible for charges not covered by this authorization. Should the account be referred to a collection agency for collections, the undersigned also shall pay reasonable collection expenses.
I acknowledge that I have read this consent form and have had the opportunity to ask questions.

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Print Name of patient and date of birth

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Signature of patient/responsible party and date