INSURED'S INFORMATION

THE INSURED IS THE PERSON WHO CARRIES THE INSURANCE THROUGH THEIR EMPLOYER. PLEASE COMPLETE INFORMATION TO GENERATE YOUR BILLS TO BE TRANSMITTED ELECTRONICALLY TO YOUR PAYER. THANK YOU.

Insured name: ____

Insured Date of Birth: ________________________ **Gender:** F / M

AUTHORIZATION TO RELEASE INFORMATION

PLEASE BE ADVISED THIS OFFICE CANNOT LEGALLY BILL YOUR INSURANCE WITHOUT AN AUTHORIZATION TO RELEASE INFORMATION SIGNED BY THE PATIENT OR AUTHORIZED PERSONS'S SIGNATURE.

I Authorize the release of any medical information necessary to process this claim and request payment of Medical Benefits either to myself or the party who accepts assignment of benefits.

Signed: ____________________________________ Date: ______________

(Patient's or Authorized Person's Signature)

AUTHORIZATION TO PAY PHYSICIAN AND/OR GROUP

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE, OF THE MEDICAL EXPENSE BENEFITS OTHERWISE PAYABLE TO ME

BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID PHYSICIAN AND/OR GROUP ON THE ACCOUNT OF

THE ENCLOSED CHARGES.

Date: __________________ Signed: ____

(Signature must be Employee and/or Policyholder)

NOTE: THE ASSIGNMENT OF BENEFITS WILL NOT BE MAILED WITH YOUR INSURANCE FORMS IF THE ACCOUNT IS PAID IN FULL AT THE TIME THE INSURANCE IS BILLED.