Authorization and Assignment of Benefits to Tri-State Orthopaedic Specialists

Consent for treatment: I hereby give consent to Tri-State Orthopaedic Specialists and the staff of Tri-State Orthopaedic Specialists to perform medical procedures which are appropriate for my condition, symptoms, illness(es) or injur(ies). I also give the same consent for minor child or children.

Assignment of insurance benefits: I hereby assign to Tri-State Orthopaedic Specialists the benefits of any and all insurance policies, including **Health Insurance and Personal Injury Protection (PIP)** to which I may be entitled.

Authorization for direct payment: I hereby direct any and all insurance companies to make direct payment to Tri-State Orthopaedic Specialists for all services, items and/or supplies furnished to me or my family members, as the case may be. I request that all payments to Tri-State Orthopaedic Specialists be sent directly to the billing address. I also authorize my attorney to make prompt payment to Tri-State Orthopaedic Specialists any sums which may be due, and owing from the proceeds of any settlement, judgment or insurance payment, including services or supplies heretofore supplied and those supplied to the time of settlement, judgment or insurance payment.

Release of medical information and treatment records: I hereby authorize the release of any medical or psychological information necessary to submit, document or process insurance claims on behalf of me or my family members.

Responsibility for payment: Except where prohibited by law, statute or regulation, I understand that I remain directly and personally responsible to Tri-State Orthopaedic Specialists, for all charges submitted by him which pertain to me or my family members, and that nothing in this authorization and assignment shall be construed to waive my obligation to forward Tri-State Orthopaedic Specialists payment from all or any portion of insurance payments received by me for health care services. I agree to payment of additional charges to Tri-State Orthopaedic Specialists of 1.5% each month on outstanding balances that are over thirty (30) days in arrears (annual percentage rate = 19.6%). I agree to be responsible for all expenses, including reasonable attorney's fees of not less than fifteen (15) percent of the amount outstanding, court costs and administrative time incurred by Tri-State Orthopaedic Specialists in collection of monies due and owing by me.

Waiver of statute of limitations: In consideration of courtesy and patience extended to me by Tri-State Orthopaedic Specialists, I hereby agree that the statute of limitations with respect to any claim for charges for services by Tri-State Orthopaedic Specialists shall not begin to run until there is a denial by me, in writing and sent by certified mail with return receipt requests, of any balance claimed to be due and owing Tri-State Orthopaedic Specialists.

Assignment of cause or action: In the event that any insurance company which is obligated by contract, statute, or law to make a payment to me or to Tri-State Orthopaedic Specialists for professional services refuses to make such payment upon demand by Tri-State Orthopaedic Specialists, I hereby assign and transfer to Tri-State Orthopaedic Specialists to prosecute any such action in my name and/or his name to compromise, settle, or otherwise resolve said claim as he sees fit.

Revocation: This assignment may be revoked only in writing by me and only if such revocation is sent by certified mail, upon receipt, to Tri-State Orthopaedic Specialists. A photocopy of this assignment and authorization shall be binding as an original.

HIPAA: I have read your poster in regards to HIPAA.

Name: ______________________________ Date: ______________________________

_____I give my permission for the office of Dr. Tom Ghobrial to leave a message on my answering machine regarding:
( ) test results, ( ) appointments, ( ) account information.

_____I give permission for the office to speak to a family member regarding:
( ) appointment times, ( ) test results, ( ) account information.

_____I give permission ( ) I do not give my permission for the office of Dr. Tom Ghobrial to phone my place of employment to reschedule appointments (only if necessary).

I do not give permission for: ____
____

Patient Signature: ______________________ Date: ______________ Expiration Date: ______________