The Center for Orthopedic Surgery
4642 North Loop 289, Suite 101
Lubbock, Texas 79416
Phone: (806)797-4985 / Fax: (806)792-8588

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits to which I might be entitled, including Medicare, private insurance, liability, worker's compensation and all other health plans to **The Center for Orthopedic Surgery** for services provided and not yet paid in full.

PAYMENT POLICY:
I understand that all medical and surgical charges incurred by me, or my dependents, for services rendered are my financial responsibility and that all fees necessary to collect this amount are payable by me.

Patient's who have insurance coverage with a health plan that their physician is a contracted, participating provider (such as Medicare, worker's compensation, Medicaid and some managed care plans) are responsible for payment of any deductible, co-payments and non-covered services. Insurance claims will be filed for the patient.

Unless prior arrangements have been made, patient's covered by health plans which their physician is not a contracted provider or a patient without insurance coverage are responsible for payment in full at the time of service.
Insurance claims will be filed for patient only in cases where surgery is required.

My signature below is applied to all of the above statements and is valid indefinitely or until revoked in writing by me.

Print Name:______________________________ SS#:______________________

Signature:________________________________ Date:______________________

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RELEASE OF INFORMATION:
I hereby authorize **The Center for Orthopedic Surgery** to disclose all or any part of my medical records or other information about me to any organization needing such information to determine benefits or process benefits payable for services provided.

INFORMED CONSENT:
You have the right to decide what may be done to your body during the course of medical treatment. Your physician, (or employees designated by your physician) will discuss with you the nature of your condition, the proposed treatment and any alternate procedures that are available. Your physician, (or employees designated by your physician) also will provide you with information about the risks associated with certain medical procedures. This information will help you make an informed decision about the kind of treatment you want to receive.

My signature below is applied to all of the above statements and is valid indefinitely or until revoked in writing by me.

Print Name:______________________________ SS#:____________________

Signature:_________________________________ Date:____________________