

PRIMARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

SECONDARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

ASSIGNMENT OF BENEFITS: I authorize payment of benefits directly to Rockland Orthopedics & Sports Medicine for services rendered. For purposes of payment or audit, I authorize the release of any information acquired in the course of my examination or treatment; I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

SIGNED: _____ DATE: _____

I understand that I am personally responsible to the provider for payment for services rendered.

SIGNED: _____ DATE: _____

BILLING INFORMATION ACKNOWLEDGMENT

I _____, understand and agree that it is my responsibility to be familiar with my medical insurance policy. I agree to provide correct referrals and authorizations. I will pay in full at the time of service if I do not have this information, and I accept responsibility for payment of the entire bill.

Furthermore, I accept and understand that any balances not covered by my insurance(s) are to be paid upon receipt of my bill. If my insurance company has not provided payment, I am responsible for the balance and for contacting the insurance company.

I agree that if my balance due to Rockland Orthopedics and Sports Medicine, PC remains unpaid I will be responsible for interest on the unpaid balance at the rate of 18% per annum, plus cost of collection and reasonable legal fees.

Name Signature Date