

**ASSIGNMENT OF BENEFITS, DIRECTION TO PAY, RELEASE OF INFORMATION,
AND LIFE TIME MEDICARE PART B SIGNATURE AUTHORIZATION.**

ASSIGNMENT BENEFITS: The undersigned patient assigns the benefits of insurance and any over due interest payments under the no-fault Policy of Automobile Insurance, also known as Personal Injury Protection (P.I.P.), or Medical Payments policy of insurance with my insurance carrier or the responsible insurer to **ORTHOPAEDIC CENTER OF SOUTH FLORIDA, PA** for services rendered. The medical provider agrees to accept the irrevocable assignment of benefits for services rendered to the patient. This assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid as an original. The undersigned patient agrees to pay any applicable deductible, co-payments, or for any and all other services not covered by the insurance policy. **DIRECTION TO PAY:** The undersigned patient further directs the insurer to pay **ORTHOPAEDIC CENTER OF SOUTH FLORIDA, PA** directly for the services rendered. **RELEASE OF INFORMATION:** I hereby authorize **THE ORTHOPAEDIC CENTER OF SOUTH FLORIDA, PA** to furnish my insurance company or companies, or their representatives with any and all information that may be contained in their medical records.

X _____ DATE: _____
(Patient's signature or parent's signature if patient is a minor)

LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers or the billing agent of **ORTHOPAEDIC CENTER OF SOUTH FLORIDA, PA** any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and coinsurance.

X _____ DATE: _____ MEDICARE # _____
(medicare signature only)

IF PATIENT IS UNDER 18:

I hereby give my permission for _____ to be treated by
Dr. _____.

X _____ DATE: _____

Signature/Telephone Verification

Witness X _____ DATE: _____

Patient unable to sign due to _____

Witness X _____ DATE: _____