

ORTHOMED CENTER

Orthopedic & Sports Medicine Center

**“SIGNATURE ON FILE” AUTHORIZATION
Statement to Permit Payment of Medicare or
Any Other Health Insurance Benefits to Supplier, Physician, or Patient**

Name of Patient (beneficiary)

Health Insurance Claim Number

I request that payment of authorized Medicare or any other health insurance benefits be made either to me or on my behalf to above noted physician/supplier for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient (beneficiary) Signature

Date



**AUTHORIZATION FOR TREATMENT &
RESPONSIBILITY OF ACCOUNT**

- I have provided the necessary medical information and I authorize treatment.
- I understand the charges on my account **ARE MY RESPONSIBILITY REGARDLESS** of insurance coverage and agree to make payments to keep the account current pending receipt of insurance monies. **IF MY INSURANCE IS AN HMO OR PPO,** I understand I am responsible for my co-payment or the portion indicated by my carrier.

Patient Signature

Date