

Patient Name: _____

Chart #: _____

Carolina Orthopaedic Specialists

ASSIGNMENT OF BENEFITS, INFORMATION RELEASE AND PATIENT RESPONSIBILITY FORM

I hereby assign, transfer and convey payment and authorize said payment to be made directly to Carolina Orthopaedic Specialists for any medical/surgical benefits, sick benefits, injury benefits due because of a third party, or proceeds of all claims resulting from liability of a third party, payable by any party, organization etc. to or for discharge or completion of all outstanding obligations etc., related to this medical treatment. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full.

I understand that I am responsible for any charges not covered by my insurance company and for deductible and co-pays. The undersigned individually obligates himself/herself to pay the account of the provider as follows:

All self-pay charges, co-pays and deductible are due in full at the time service is rendered.

If payment cannot be made in full for surgical procedures, prior arrangements can be made through our Central Business Office upon request.

Should the account be turned over to a collection agency or attorney for collection, the undersigned shall pay all collection fees up to 25% in addition to the bad debt balance once placed with a collection agency and/or court cost and reasonable attorney fees.

The undersigned agrees that any patient or guarantor overpayment collected on the account may be applied to a delinquent account of the patient or any delinquent accounts for which the patient or guarantor is legally responsible for at the time of the collection of the payment.

I hereby authorize the release of any and all information necessary to secure the payment of benefits.

My signature below indicates that the information provided for billing purposes is accurate and complete to the best of my knowledge and is only for the use in the treatment, billing and processing of insurance benefits for which I am entitled.

I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Name (Printed) / Relationship to Patient

Name (Signed)

Witness

Date



Mark S. Brazinski, MD
 Donald A. Campbell, MD
 Christopher T. Daley, MD
 John L. dePerzel, MD

Alfred E. Geissele, MD
 Matthew D. Hannibal, MD
 Jeffrey P. Keverline, MD
 Timothy H. Kirkland, MD

Robert L. Liljeberg, Jr., MD
 Christopher R. Martin, MD
 Ralph J. Maxy, MD
 John T. McCormick, MD

Stephen J. Sladicka, MD
 James E. Stanislaw, MD
 Mark A. Tiffany, MD
 Earl W. Walker, Jr., MD

Date Updated	Responsible Party's Signature