

Patient's Name: _____
(Please Print)

Date of Birth: _____

Assignment of Insurance Benefits / Personal Responsibility for Payment / Release of Medical Information

I hereby authorize my insurance benefits to be paid to Hand Surgery Specialists, Inc., realizing I am responsible for payments of co-payments, deductibles and non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers, including Worker Compensation carriers against which I have made, or shall hereafter make, a claim.

Consent to Treatment

I hereby authorize Hand Surgery Specialists, Inc. and any of its physicians and other healthcare professionals and assistants to provide and render such medical care and treatment to the above named patient as is necessary under the circumstances, including, without limiting the generality of the foregoing, any of the following: physical examination, x-rays, medication, and office surgical procedures. I hereby authorize the physicians of Hand Surgery Specialists, Inc. to give me reasonable and proper medical care by today's standards.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ My initials acknowledge that I have been offered a copy of Hand Surgery Specialists Notice of Privacy Practices.

Designation of Personal Representative

I designate the person listed below to be my personal representative, enabling them to act on my behalf for the purpose of consenting to or authorizing the use and disclosure of my protected health information.

Personal Representative	Relationship of Personal Representative to Patient

If you are referred for occupational therapy or diagnostic testing, it is your responsibility to verify insurance **PRIOR** to your appointment. If an authorization is needed, please contact our office or the therapy department. This will not be done automatically by our office.
If you do not take responsibility for the above, the medical facility will have no choice but to bill you directly for service rendered if rejection results from lack of referral.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature _____ Date _____

Statement to Permit Payment of Medicare Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians of Hand Surgery Specialists, Inc. for any services furnished me by these physicians. I authorize release to the Health Care Financing Administration and its agents any medical information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____