SOUTHEAST
ORTHOPEDIC SPECIALISTS

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Name:_____ **DOB:** _____

Authorization and Assignment of Benefits:

For the services rendered and those about to be rendered, I hereby assign to Southeast Orthopedic Specialists, all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Southeast Orthopedic Specialists and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Southeast Orthopedic Specialists. I understand that I am directly and primarily responsible to Southeast Orthopedic Specialists for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Southeast Orthopedic Specialists to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

_____ _____

Signature **Date**

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Southeast Orthopedic Specialists for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

_____ _____

Signature **Date**