Authorization and Assignment of Insurance Benefits

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to the following:

1. I authorize payment of medical benefits to the provider rendering services.

2. I agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, services rendered or service to be rendered without obtaining my signature on each and every claim submitted for myself and or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

3. I will pay to Koman Orthopedics and Sports Medicine any balance due for services rendered. I understand that if full payment is not made on my behalf by my (insurer, legal representation, or workers compensation insurance) I will be responsible for any outstanding balance.

4. Accounts are considered past due after 30 days. A service charge of $25 plus the rebilling fee will be added to your account if your check is returned from your bank for any reason. Bills turned over to our collection agency will be subject to a collection surcharge of 30% of the account balance. Other fees will apply if the account is forwarded to an attorney for a collection lawsuit. **Any additional medical services will be suspended until your account is paid in full.**

I agree to the statements set forth above in the authorization and assignment of insurance benefits.

______________________________________ ______________________
Patient Signature (or agent/representative) Date

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Print Name