

**ASSIGNMENT OF BENEFITS, DIRECTION TO PAY, & RELEASE OF INFORMATION:**

**ASSIGNMENT OF BENEFITS:** The undersigned patient assigns the benefits of insurance and any over due interest payments under the No-fault Policy of Automobile Insurance, also known as Personal Injury Protection (P.I.P.), or Medicare Payments Policy of Insurance with my insurance carrier or the responsible insurer to **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** for services rendered. The medical provider agrees to accept the irrevocable assignment of benefits rendered to the patient. This assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid and original. The undersigned patient agrees to pay any applicable deductible, co-payments, or any and all other services not covered by the insurance policy. **DIRECTION TO PAY:** The undersigned patient further directs the insurer to pay **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** directly for the services rendered. **RELEASE OF INFORMATION:** I hereby authorize **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** to furnish my insurance company or companies, or their representatives with any and all information that may be contained in their medical records.

X \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient's signature or parent's signature if patient is a minor)

**LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION:** I authorize my holder of medical or other information about me to release to the Social Security Administration, its intermediaries, carriers, or the billing agent of **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and insurance.

X \_\_\_\_\_ Date: \_\_\_\_\_ Medicare#: \_\_\_\_\_  
(Medicare signature only)

**IF PATIENT IS UNDER 18:**

I hereby give my permission for \_\_\_\_\_ to be treated by Dr. \_\_\_\_\_.

X \_\_\_\_\_ Date: \_\_\_\_\_

Patient unable to sign due to \_\_\_\_\_.

Witness X \_\_\_\_\_ Date: \_\_\_\_\_



**SOUTHWEST ORTHOPEDIC GROUP, L.L.P.**

COMMUNICATION for TEST RESULTS

NOTICE TO PATIENT:

*In order for our practice to respond promptly and accurately to your needs, use this form to make a request of how you would like to receive TEST RESULTS. Check one:*

- I will receive my results in person at your facility.
- You may call me at the following number: \_\_\_\_\_
- You may leave a voicemail stating for me to call your facility (Results will NOT be left on voicemail).
- You may mail the results to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_

*Please list any person(s) whom you would like to have access to your medical information:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*For certain test results, our physicians may request that you return to the facility for a second visit and follow-up care.*

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# ***SOUTHWEST ORTHOPEDIC GROUP, LLP***

## **Review of Notice of Privacy Practices**

### **Acknowledgement:**

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
**Patient or Personal Representative  
Signature**

\_\_\_\_\_  
**Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: \_\_\_\_\_.

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### **Financial Policy Statement**

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_  
**Patient or Responsible Party**

\_\_\_\_\_  
**Date**