

# ALLSTAR ORTHOPEDICS

## AUTHORIZATION/RESPONSIBILITY AGREEMENT/CONSENT FOR TREATMENT

This is to certify that I/we the undersigned, authorize the examination, operation, or treatment as may be necessary or advisable by ALLSTAR ORTHOPEDICS.

1. I, the undersigned as the patient or his/her authorized representative do hereby authorize ALLSTAR ORTHOPEDICS to release my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. ALLSTAR ORTHOPEDICS is also hereby authorized to release to my physician(s), whether as individuals or as a professional association, to perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes.

2. I understand that my medical records may be transmitted electronically and I understand that they may be received by someone other than the person intended or a third party; I absolve ALLSTAR ORTHOPEDICS, from all responsibility.

3. I hereby authorize any insurance company; to pay the proceeds of any benefits due me directly to ALLSTAR ORTHOPEDICS. A copy of this can be considered as an original for insurance purposes.

4. I acknowledge and understand that I am responsible for all the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

5. Further following demand or billing, should ALLSTAR ORHTOPEDICS turn the collection of this account over to a collection agency or attorney, additional sum of up to 40% of the unpaid balance may be charge to this account.

6. I have read this agreement and understand its contents.

**SIGNED** \_\_\_\_\_

**WITNESS** \_\_\_\_\_

**DATE** \_\_\_\_\_