INFINITY ORTHOPEDICS

COORDINATION OF BENEFITS:
YOUR INSURANCE POLICY PROVIDES FOR BENEFITS TO BE COORDINATED WITH OTHER MEDICAL INSURANCE UNDER WHICH YOU ARE COVERED. YOUR PRIMARY INSURANCE CARRIER PAYS FIRST IF YOU ARE COVERED BY ANOTHER, SECONDARY INSURANCE.

PRIMARY INSURANCE _____ID#_____GROUP#_____

SUBSCRIBER(PLEASE CHECK) SELF_____OTHER_____

IF YOU ARE NOT THE SUBSCRIBER FILL OUT THE FOLLOWING:

NAME_____RELATIONSHIP_____ DOB _____

ADDRESS_____CITY_____STATE_____ZIP_____

SECONDARY INSURANCE _____ID#_____GROUP#_____

SUBSCRIBER(PLEASE CHECK) SELF_____OTHER_____

IF YOU ARE NOT THE SUBSCRIBER FILL OUT THE FOLLOWING:

NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

IF YOUR INSURANCE HAS A PRE-EXISTING HEALTH CLAUSE, PAYMENT FOR TREATMENT RENDERED MAY BE DENIED.

SHOULD THIS OCCUR, YOU WILL BE RESPONSIBLE FOR PAYMENT.

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ASSIGNMENT OF BENEFITS

I, _____ (NAME)

-AUTHORIZE AND ASSIGN ALL PAYMENTS FROM MY INSURANCE TO GO DIRECTLY TO INFINITY ORTHOPEDICS. SHOULD I RECEIVE THESE PAYMENTS, I WILL FORWARD TO INFINITY ORTHOPEDICS
-AUTHORIZE MY INSURANCE COMPANY TO RELEASE ANY AND ALL BENEFIT INFORMATION TO INFINITY ORTHOPEDICS FOR PROPER CLAIMS PROCESSING.
-AUTHORIZE INFINITY ORTHOPEDICS TO FILE CLAIMS ON MY BEHALF AND REPORT ANY SUSPECTED CLAIM VIOLATIONS TO THE PROPER AUTHORITIES.
-UNDERSTAND THAT I WILL BE RESPONSIBLE FOR DENIED CLAIMS DUE TO LACK OF REFERRAL (IF REQUIRED)OR IF I AM NOT COMPLIANT IN ANSWERING QUESTIONNAIRES FROM MY INSURANCE COMPANY.
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PATIENT LIABILITY AGREEMENT:
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL BILLS INCURRED WHILE UNDER THE TREATMENT OF INFINITY ORTHOPEDICS. IN THE EVENT THAT MY ACCOUNT IS NOT PAID IN FULL, I SHALL BE LIABLE FOR ANY AND ALL PAYMENTS THAT NEED TO BRING MY ACCOUNT INTO GOOD STANDING. IF MY ACCOUNT IS PAST DUE AND I CANNOT MAKE FULL/PARTIAL PAYMENT AT THE TIME OF SCHEDULED VISIT, MY APPOINTMENT MAY BE CANCELLED. IF MY ACCOUNT IS IN COLLECTIONS, NO TREATMENT SHALL BE RENDERED. OUR BILLING DEPARTMENT WILL WORK WITH YOU TO SET UP A PAYMENT PLAN IF NEEDED.

SIGNATURE_____DATE_____