Bryan Matanky, M.D
Vanessa Gordon, PA-C Kelsy Rokey, PA-C Kristi Preston, PA-C
1760 E Florence Blvd, Suite 120 Casa Grande, Az 85122

Today's Date: _____

AUTHORIZATION FOR:

ASSIGNMENT OF BENEFITS, RESPONSIBILITY FOR NON-COVERED SERVICES, RELEASE OF INFORMATION

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS PAYABLE BY ANY FEDERAL OR STATE HEALTH CARE PROGRAM OR COMMERCIAL PAYER BE MADE EITHER TO ME ON MY BEHALF TO ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C FOR ANY SERVICES FURNISHED TO ME BY ITS PHYSICIANS OR EMPLOYEE AT ANY LOCATION. I AUTHORIZE ADVANCED ORTHOPAEDICS & SPORTS MEDICINE P C TO REALEASE TO ITS BILLING AGENTS. THE HEALTH CARE FINANCING ADMINISTRATION. ITS AGENTS AND MY INSURER AS APPLICABLE, ANY INFORMATION (INCLUDING, BUT NOT LIMITED TO INFORMATION REGARDING DRUG AND ALCOHOL PROGRAM PARTICIPATION, DIAGNOSIS, PROGNOSIS, TREATMENT OR REFERRAL) NEEDED TO DETERMINE THESE BENEFITS, THE BENEFITS PAYABLE FOR RELATED SERVICES OR TO OBTAIN PAYMENT FOR SERVICES PROVIDED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO THE RELEASE AT ANYTIME, EXCEPT TO THE EXTENT RELIED UPON BY ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C OR THE DISCLOSURE IS AUTHORIZED BY LAW. THIS CONSENT TO THE RELEASE OR PAYMENT INFORMATION REMAINS VALID UNTIL EXPRESSINGLY REVOKED BY ME IN WRITING I UNDERSTAND THAT I AM PRIMARILY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES PROVIDED.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ANY AUTHORIZATIONS OR REFERRALS REQUIRED BY MY INSURANCE, AS WELL AS KNOW MY COPAYS AND DEDUCTIBLES REQUIRED BY MY INSURANCE.

I UNDERSTAND THAT IF MY COPAY IS NOT LISTED ON MY INSURANCE CARD THAT I WILL BE BILLED FOR IT.

I UNDERSTAND THAT IT IS MY RESPONSIBLITY TO NOTIFY AOSM OF ANY AND ALL INSURANCE CHANGES PRIOR TO MY APPOINTMENT.

Financial Agreement

Patient/Guarantor agrees to pay all costs of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Print Patient Name: _____

Signature: _____ Today's Date: _____