PREMIER ORTHOPAEDIC & HAND CENTER S.C.

INSURANCE INFORMATION FORM

PATIENT:_____

INSURANCE:

PRIMARY: Name of Company_____

Name of Insured Person_____Relationship to Patient_____

Date of Birth ___/___/_____Social Security_____

Group #_____ID_____

SECONDARY: Name of Company_____

Name of Insured Person_____Relationship to Patient_____

Date of Birth___/___/_____Social Security_____

Group #_____ID_____

I authorize Premier Orthopaedic & Hand Center S.C. to release information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I authorize and direct my insurer to issue payment for services directly to Premier Orthopaedic & Hand Center S.C. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. Regardless of my insurance benefits, if any, I understand that I am responsible for fees and services rendered. In the event of non-payment, I understand that I am responsible for collection, attorney, and court costs. Additionally, I authorize Premier Orthopaedic & Hand Center S.C to initiate a complaint to the Insurance Commissioner on my behalf.

Signature:_____Date:_____/____/____

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Premier Orthopaedic & Hand Center S.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the HEALTHCARE FINANCING ADMINSTRATION and its agents any information needed to determine those benefits payable for related services.

Signature:_____Date___/____/_____