

Acct #: _____



MEDICAL HEALTH COVERAGE

Financial Responsibility

- Insurance billing by Corona Orthopaedic Medical Group is provided as a courtesy.
- Any charges not covered by health care benefits are the patient's responsibility.
- It is my responsibility to notify the office of any changes in my health care coverage.
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill, or balance of the bill, as determined by the office, and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Authorization of Release of Information

I authorize the release of medical or any other information to the Health Care Financing Administration, my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Corona Orthopaedic Medical Group Inc. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file.

My insurance is: _____

Primary Care Physician: _____

Medical Group: _____

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Patient Name (Please Print)

Insured Name (Please Print)

Patient/Insured's Signature

Date