Consents

Assignment of Benefits. I hereby authorize Orthopaedic Specialists of Austin to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment directly to Orthopaedic Specialists of Austin for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after, the date provided on this form.

I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization of benefits in no way releases me from said responsibility and imposes no obligation on Orthopaedic Specialists of Austin to collect money on my behalf.

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Printed name of patient or responsible party

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Signature of patient or responsible party Date

Acknowledgement of Receipt of Notice of Privacy Practices. I have received a copy or reviewed a copy of the Notice of Privacy Practices for Orthopaedic Specialists of Austin, and I understand that Orthopaedic Specialists of Austin reserves the right to modify the privacy practices outlined in the notice.

****Please note**** *Orthopaedic Specialists of Austin might contact you for scheduling purposes, appointment reminders, payment reasons, or other aspects of your care. Unless you give us written notification otherwise, we will leave a message on your answering machine or with someone who answers your phone, if you are not home.*

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Printed name of patient or responsible party

____ ____________

Signature of patient or responsible party Date