



1600 Esplanade, Suite C ● Chico, CA 95926
(530) 897-4500 ● Fax (530) 897-4544

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

MEDICARE/ SUPPLEMENTAL INSURANCE

I request that payment of authorized Medicare and/or insurance benefits be made to Orthopedic Associates of Northern California. I authorize the release of medical information necessary for the processing of my insurance claim and to other health care providers for continuity of care. The physician agrees to accept the Medicare allowed amount as the total reimbursement, and the patient is only responsible for the deductible, co-insurance and noncovered services. I understand I will receive a statement each month if my account has a balance due and a finance charge of 1% per month will be charged on all past due accounts.

X _____
Beneficiary Signature

Date

PRIVATE INSURANCE /PRIVATE PAY/ WORKERS COMPENSATION/MEDI-CAL

I request that payment of authorized insurance benefits be made to Orthopedic Associates of Northern California. I authorize the release of medical information necessary for the processing of my insurance claim and to other health care providers for continuity of care. I understand that I am responsible for charges not covered by insurance. I understand I will receive a statement each month if my account has a balance due and a finance charge of 1% per month will be charged on all past due accounts.

X _____
Insured or Guardian's Signature

Patient's Signature

Date

MINORS AUTHORIZATION TO TREAT A MINOR

I hereby authorize the physician whose name appears below and/or assistants supervised by him to treat my minor child named _____. I am aware that my child may require treatment when I am not able to be present. I authorize on going care until it is revoked by the undersigned parent or guardian.

X _____
Insured or Guardian's Signature

Patient's Signature