



PATIENT NAME: _____

RELEASE OF INFORMATION AND GUARANTEE OF PAYMENT

1. Release of information- I hereby authorize New West Sports Medicine & Orthopaedic Surgery, P.C., to release any and all of my/the patient's medical records verbally, via facsimile, via photocopying, or via on site review to other health care institutions to whose care I may be transferred or am being evaluated for transfer to, and agencies or physicians that may become involved in further treatment or follow-up care, to my/the patient's insurance company or third party payor, for utilization review purposes and for the purpose of New West Sports Medicine & Orthopaedic Surgery, P.C. to release my/the patient's general status information to relatives and friends.
2. Medicare/Medicaid Authorization- I, whether signing as patient or agent, hereby authorize New West Sports Medicine & Orthopaedic Surgery, P.C. to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, to any peer review organization, or any state agency from which I/the patient am entitled to payment for medical benefits any information needed for this or a related Medicare and/or Medicare claim. I certify that the information given by me in applying for payment under 1111TitleXVIII and Title XIX of the Social Security Act is correct.
3. Assignment of benefits and authorization to bill- I, whether signing as patient or agent, authorize billing by and direct payment to New West Sports Medicine & Orthopaedic Surgery, P.C. of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of me or the patient for these services, including emergency services if rendered, at a rate not to exceed New West Sports Medicine & Orthopaedic Surgery's regular charges. The term "insurance benefits: as used herein includes all insurance benefits including but not limited to health insurance, accident, casualty insurance, medical payments coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement. In consideration of goods and services provided, the undersigned gives New West Sports Medicine & Orthopaedic Surgery, P.C., irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her on his/her behalf for services provided by New West Sports Medicine & Orthopaedic Surgery, P.C. I direct all insurance companies, health plans, governmental agencies and their agents or contractors, and attorneys to make such payment directly to New West Sports Medicine & Orthopaedic Surgery, P.C.
4. Guarantee of payment- For good and valuable consideration of services to be rendered to me/the patient identified on this sheet, I hereby guarantee payment of the entire medical bill expense incurred at New West Medicine & Orthopaedic Surgery, P.C.

MY SIGNATURE BELOW INDICATES THAT THIS INFORMATION HAS BEEN EXPLAINED TO ME. I HAVE READ THIS FORM OR IT HAS BEEN READ TO ME. I UNDERSTAND THIS AGREEMENT FULLY.

Signature of Patient

Date

Signature of Patient/Guardian

Witness