Sports Medicine & Orthopedic Center, S.C.

RELEASE OF INSURANCE INFORMATION

I hereby authorize Sports Medicine and Orthopedic Center, S.C. to furnish the insurance companies listed below, all information which said companies may request concerning my present illness or injury, or any other insurance company that is associated with my care.

I hereby assign to Sports Medicine and Orthopedic Center, S.C., all sums payable to be from the amount of money to which I am entitled for medical and/or surgical expenses, but not to exceed the charges for those services. **I understand that I am financially responsible for those charges not paid by my insurance.**

Insurance copays are payable at the time of every visit to our office.
We have a contract with your insurance carrier that requires us to collect the copay each time you see the doctor or therapist. For your convenience, we accept Cash, Check, Debit Card, and Credit Card. Your appointment could be rescheduled if you are not prepared to pay your copay at the time of each visit.

I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

NAME OF INSURANCE COMPANY: PRIMARY ______________________________

SECONDARY ______________________________

DATE ____

SIGNED ____

RELEASE OF MEDICAL INFORMATION

In addition, you are hereby authorized to give to______________________________

Address: ____

City/State/Zip: ____

or any representative thereof, any and all *information* which may be requested regarding my physical condition and treatment rendered, and to allow them, or any physician appointed by them, to examine any x-ray picture taken of me, or records which you may have regarding my condition or treatment.

Signed____ Date __________________

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