

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Salem Orthopedic Surgeons, Inc. for any services furnished by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefit payable for related services.

Signature of Patient

Date

Assignment of Benefits

ASSIGNMENT OF BENEFITS TO PHYSICIAN: I hereby authorize assignment of payments directly to Salem Orthopedic Surgeons, Inc. for the surgical and/or medical benefits, if any, otherwise payable to me for the services described above. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize Salem Orthopedic Surgeons, Inc. to release any information relative to medical care received by me.

Signature of Patient, Parent, or Guardian

Date

HIPAA Compliance Acknowledgement

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Policies.

Signature of Patient, Parent, or Guardian

Date