AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

Patient Name:_____ Date:_____

Physician:

I hereby authorize the above named physician and Northtowns Orthopedics, P.C. to release medical and other information relative to services rendered, to perform services necessarily incident to such treatment, and to ensure confidentiality.

I hereby authorize payment of medical benefits to the above named doctor and Northtowns Orthopedics, P.C. and I understand that I am financially responsible to the physician and Northtowns Orthopedics, P.C. for charges not covered by my insurance carrier, unless other arrangements have been made. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I understand should my claim be rejected by an insurance company or is determined that my claim was not a result of workers compensation or an automobile accident, the undersigned shall pay the usual and customary fees for services rendered.

Signature:_____

Should you wish to have your balance applied to your Visa, Mastercard or American Express please complete the following:

Card # _____ Exp Date:_____

Signature of Cardholder:_____