ORTHO SPINE AMERICA

John G. Atwater, MD-PA
Sheree Ewar, ARNP

Name _____ DOB _____

Authorization and Assignment of Benefits

For the services rendered and those about to be rendered, I hereby assign to John G. Atwater, MD-PA and Sheree Ewar, ARNP all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the insurance company to pay said benefits directly to John G. Atwater, MD-PA and Sheree Ewar, ARNP, and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to John G. Atwater, MD-PA or Sheree Ewar, ARNP. I understand that I am directly and primarily responsible to John G. Atwater, MD-PA and Sheree Ewar, ARNP for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days in their paying), it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all costs of collection, including filing fees and reasonable attorney fees. I hereby authorize John G. Atwater, MD-PA and Sheree Ewar, ARNP to release to my insurance company any information acquired, including diagnosis and the records in the course of my treatment.

Signature _____ Date _____

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or related to Medicare claims. I request that the payment of authorized benefits be payable to John G. Atwater, MD-PA or Sheree Ewar, ARNP on my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare on my behalf.

Signature _____ Date _____