

FRANCISCO J. BORJA, M.D., P.A.
ORTHOPEDIC SURGEON

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my Insurance Co. _____ to make payments on my behalf, of any and all Individual, Group, W/C, Liability, or PIP benefits, directly to the provider **Francisco J. Borja, M.D.**

MEDICARE / MEDICAID ASSIGNMENT OF BENEFITS

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security act is correct, and I request that Medicare, Medicaid, Medigap, and Supplementary Insurance Companies make payments of authorized medical benefits directly to **Francisco J. Borja, M.D.** on my behalf.

CONSENT FOR TREATMENT


I hereby voluntarily consent to the rendering of medical treatment by **Francisco J. Borja, M.D.** and/or his medical staff, which may include; routine diagnostic and/or surgical procedures, x-rays, administration of injections, and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

RELEASE OF INFORMATION

I hereby authorize **Francisco J. Borja, M.D.** and/or his staff to release any medical information acquired in the course of my examination and treatment, necessary for the processing of this claim and/or for the purpose of any insurance payments. I further authorize release of said information to my Primary Care Physician, Referring Physician, and/or Attorney if when applicable.

GUARANTY OF PAYMENT

I have been advised that verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment by my Insurance Company remains subject to all of the terms and conditions of my benefit plan, including exclusions and limitation. If my coverage has a pre-existing condition exclusion, payment will be subject to pre-existing investigation at the time claims are filed. I hereby understand that I am financially responsible for payment to **Francisco J. Borja, M.D.** for any charges not covered or allowed by my Insurance Company, as well as all applicable deductible's, co-insurances, co-payment's; patient responsibilities amounts, and/or for any balances remaining after payment has been made by my Insurance Company. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to **Francisco J. Borja, M.D.** plus the cost of collection fees, and/or including reasonable attorney fees if or when applicable.

I _____  **[Print Name]** Acknowledge that this form has been fully explained to me and that I have read and understand each of the provision listed above, and that by my signing this form, I consent to these provision individually and collectively.

Patient's Signature or if minor, Parent's Signature

Dated On: _____

Witnessed By: [Print Name]: _____