AUTHORIZATION FORM

I hereby authorize the physicians and ancillary providers of Basin Orthopedic Surgical Specialists, P.A. to evaluate and treat.

I also hereby authorize payment directly to **BOSS** for surgical and/or medical services and release of any information requested by my other treating physicians and/or insurance companies necessary to process medical claims.

Insurance is filed as a courtesy for our patients. Any discrepancy in payment of benefits is between the insurance company and the patient. We do not accept assignment from all insurance companies as payment in full. We have no control over what your insurance company terms as "Usual and Customary" for benefits. If, after **60 days**, we have not had a response from your insurance company, then the patient will be fully responsible for those charges.

_____ Date: _____

Patient or Parent/Guardian Signature if a Minor

OUT OF NETWORK AGREEMENT

I have been notified by **Basin Orthopedic Surgical Specialists, P.A.** that if they are not in the network with my insurance company, they will likely deny payment for healthcare services or pay at a reduced rate.

I am aware and agree to be personally and fully responsible for payment of all services rendered by and physician associated with the clinic.

_____ Date:_____

Patient Signature (Parent/Guardian if a Minor)

_____ Date:_____

Witness