

EAST COAST SPINE & ORTHOPEDICS, P.C.
330 NORTH HARRISON STREET, SUITE 4
PRINCETON, NJ 08540
Tel: (609) 955 – 1251
Fax: (888) 255 – 0370

Dr. Steven Schiebert, MD, DO

AUTHORIZATION AND RELEASE

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Assignment of Insurance benefits: I authorize payment directly to East Coast Spine & Orthopedics, P.C. for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if insurance is accepted that I must pay all applicable insurance co-pays, coinsurance, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for the service.

Release of Records: I authorize East Coast Spine & Orthopedics, P.C. to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for treatment and for quality management, utilization review, transfer, and follow-up purpose.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice to Privacy Practices of East Coast Spine & Orthopedics, P.C., I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature: _____

Date: _____

Parent of Guardian Signature: _____

Date: _____

Consent of Notification of test results: I give permission to East Coast Spine & Orthopedics, P.C. to notify: _____

Relationship: _____

I give permission to East Coast Spine & Orthopedics, P.C. to leave any health information on my answering machine.