

RICHARD A. WATHNE, M.D.

BENJAMIN BLAIR, M.D.

S. JEFFREY BRAY, D.P.M.

I hereby authorize Pocatello Orthopaedics & Sports Medicine Institute, P.A., and/or staff to provide any or all information to my insurance carriers in connection with my history, diagnosis, and treatment of any condition, illness, or injury with respect to the medical care provided by the above named physicians. I hereby authorize Pocatello Orthopaedics to provide information to other healthcare providers as it relates to continuity of care.

Signature

I hereby assign to Pocatello Orthopaedics & Sports Medicine Institute, P.A., all benefits for surgical and medical care payable under my insurance policy.

Signature

I understand that if for any reason benefits are not payable by my insurance carrier, I am responsible for payment of the services provided to me by Pocatello Orthopaedics & Sports Medicine Institute, P.A. I verify that the information completed on this form is correct to the best of my knowledge.

Signature

FOR MEDICARE PATIENTS ONLY:

Name (print)

Medicare number

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY RICHARD WATHNE, M.D., BENJAMIN BLAIR, M.D., OR S. JEFFREY BRAY, D.P.M., INCLUDING PHYSICIAN SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

Signature

Date