

# Ithaca Orthopaedic Group, PC

## Eligibility Guarantee Form

I, \_\_\_\_\_ hereby certify that I am covered by my **insurance plan**  
(Name of Patient/Member/Guardian)

and have verified the fact that **Ithaca Orthopedic Group, PC** (any provider) participates with my plan.

I understand that if the above is not true or I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted Medical Group or Physician.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian Signature, if minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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I, \_\_\_\_\_ hereby certify that I am not covered by any insurance and I am  
(Name of Patient/Member/Guardian)

responsible for all services rendered charges. I agree to pay in full for all services within 30 days of receiving a bill from the above noted Medical Group or Physician.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian Signature, if minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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I understand that if my care and treatment is covered by **Workers' Compensation**, Medicaid, No Fault, Private Insurance, etc, I have 30 days from the date of my initial visit to provide all necessary insurance information, policy number, etc. In event I do not provide the necessary information with that time frame, all charges will be billed at commercial rates and I will be responsible.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian Signature, if minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance, and any other plan to: Ithaca Orthopedic Group, PC, for services provided. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian Signature, if minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_