

ORANGETOWN ORTHOPEDIC ASSOCIATES

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FINANCIAL RELEASE FORM

I \_\_\_\_\_ ACKNOWLEDGE THAT I AM

SEEING DR. \_\_\_\_\_ WITHOUT ANY/OR SUFFICIENT INSURANCE

INFORMATION AND / OR REFERRAL. IN DOING SO I UNDERSTAND THAT I AM FINANCIALLY LIABLE FOR THE FULL AMOUNT OF THE SERVICE INCURRED IF MY INSURANCE COMPANY DOES NOT HONOR THE CLAIM.

DATE OF SERVICE: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

PLEASE NOTE THIS FORM IS FOR ALL INSURANCE PLANS THAT HAVE OUT-OF-NETWORK BENEFITS ONLY.

IF YOUR INSURANCE PLAN DOES NOT HAVE OUT-OF-NETWORK BENEFITS YOU MUST RESCHEDULE YOUR APPOINTMENT AND GET A REFERRAL.