TOTAL JOINT CARE

Insurance/Medical Record Authorization Form

Patient Name: _____
(Please Print Your Name)

_____ I authorize the release of my medical records to *Total Joint Care* upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.

_____ I authorize payment of my medical benefits to *Total Joint Care* for services rendered.

_____ I authorize *Total Joint Care* to give my insurance company any information about services rendered to me as necessary to process claims.

_____ I acknowledge that I received or was offered the practice's *Notice of Privacy Practices* describing the use and disclosure of confidential healthcare information.

_____ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

_____ _____
Date Signature of patient or patient's Power of Attorney

_____
(Please print the name of the person signing this document.)

570 New Waverly Place, Suite 130, Cary, NC 27518
500 Holly Springs Road, Holly Springs, NC 27540

Phone: (919) 277-0427 **Fax: (919) 233-4492**