Kern Bone and Joint Specialists
a medical group, Inc.
1921 18th Street
Bakersfield, CA 93301

Patient's Name:_____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Kern Bone & Joint Specialists, Inc. for the surgical and/or medical benefits, if any, otherwise payable to me for services rendered to me or my dependent. I also authorize my physician to release information regarding my treatment to my insurance carrier. **I understand that I am financially responsible for all charges.**

Signature_____ Date: _____

I authorize treatment of the above named patient and agree to be financially responsible for all charges relating to treatment. In the event of special financial arrangements, I agree to make payment according to written financial agreement with the office.

This authorization and agreement will remain in effect for present and future conditions until such time that I expressly rescind this agreement in writing.

I, the undersigned, hereby agree that in the event of default in payment of any amount due, if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. I hereby accept full responsibility for any charges incurred as a result of medical legal testimony provided by doctors in this office, whether requested by my attorney, or another party. The charges incurred will be billed at the rate in effect at the time when services rendered, I understand that such charges will not be covered by insurance and that I am responsible for them personally.

It is agreed and understood that payment by the responsible party will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature_____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient
Name and Address:_____