MIDWEST HAND AND WRIST SURGERY DR. DHAWAN
Caring for the Hands that Care for Others

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CONSENT TO BILL INSURANCE

Thank you for choosing Midwest Hand and Wrist Surgery, PC for your care. Please review and sign this form to provide consent for billing your insurance and handling of your financial information.

1. ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits directly to Midwest Hand and Wrist Surgery, PC or its designated provider for services rendered. I understand that any benefits otherwise payable to me will be assigned to the clinic for direct reimbursement.

2. CONSENT TO BILL INSURANCE

I authorize Midwest Hand and Wrist Surgery, PC to submit claims to my insurance carrier(s) on my behalf and to provide all necessary medical information required to process these claims. This includes electronic claim submissions when applicable.

3. PATIENT RESPONSIBILITY

I understand that I am financially responsible for any charges not covered by my insurance plan, including deductibles, copayments, coinsurance, or non-covered services. I agree to promptly pay any balance due after insurance has processed my claims.

4. RELEASE OF INFORMATION

I authorize Midwest Hand and Wrist Surgery, PC to release my medical information to my insurance company, Medicare, Medicaid, or other third-party payers as required for payment or audit purposes. I understand this authorization may be revoked in writing at any time, except to the extent action has already been taken.

5. ACKNOWLEDGEMENT

I have read and understand this consent to bill insurance. I authorize Midwest Hand and Wrist Surgery, PC to handle billing and insurance claims as described above. I acknowledge that I am ultimately responsible for payment of services rendered.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Witness/Provider: _____