Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Is this a Work Related Injury? Yes_____ No_____ Date of Injury:_____

Description of Injury: _____

Workman's Comp Info: _____

Claim #: _____

RELEASE OF INFORMATION

I authorize Dr. Joseph Licata and/or JLSurgical, LLC to release any medical information necessary to process my insurance claims.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

ASSIGNMENT OF BENEFITS

I authorize, assign and request payment of benefits to which I am entitled from my insurer, HMO, third party payor, governmental agencies, including CMS, or those who are financially liable for my medical care, be made directly to JLSurgical, LLC or Dr. Joseph Licata. I understand that I am financially responsible for all charges incurred for services rendered to me.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

GUARANTEE OF PAYMENT

In consideration of services rendered by JLSurgical, LLC/Dr. Joseph Licata, I the undersigned agree to pay JLSurgical, LLC/Dr. Joseph Licata, any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided I am informed of same prior to the rendering of said services.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____