Account Number: _____

THE INFORMATION PROVIDED IN THIS FORM IS CRITICALLY IMPORTANT AND IT IS ESSENTIAL THAT YOU READ THIS DOCUMENT VERY CAREFULLY

Fondren Orthopedic Group L.L.P. relies solely upon the information you provide to us in this statement and in the other documents you will complete in order to collect payment from your Insurance Company. If this information is inaccurate, Fondren Orthopedic Group L.L.P., will be unable to process your eligibility to receive insurance benefits from your Insurance Company, which may inhibit and hamper the processing of your claim.

Furthermore, if the information you present is inaccurate, Fondren Orthopedic Group L.L.P., may not be able to collect payment from your Insurance Company and will need to make other payment arrangements with the person requesting the services provided by Fondren Orthopedic Group L.L.P. *Providing false information on the requested forms is not a good solution and will only result in serious legal consequences in the future.*

This document is to be completed by the insured person named below.

If you do not have private medical insurance, Medicaid or Medicare coverage, please inform us of that fact so we can attempt to make alternative arrangements for your medical care.

Patient Name: _____ (Person seeking medical care)

Insured's Name: _____ (Person completing this form)

Insured's
Employer Name: _____

Insured's
Social Security #: _____

Insurance
Company: _____

Policy Number: _____

Group Number: _____

CERTIFICATIONS REGARDING ELIGIBILTY FOR MEDICAL BENEFITS

Please write your initials beside each statement indicating that you are making the certification stated therein. By writing your initials beside each statement, you are acknowledging that you understand each of these statements and that to the best of your knowledge each of these statements is true and correct. Finally, by writing your initials beside each statement you are agreeing to take any and all action necessary by the statement made therein. If you are unable to make these certifications, please inform Fondren Orthopedic Group L.L.P., of that fact immediately.

_____ I hereby certify that the Insurance Company named above is my current medical insurance provider and that I or my family member is currently entitled to receive any and all medical benefits provided under this policy.

_____ I hereby certify that I am currently employed by the Employer named above and that I have not been terminated nor have I resigned my position with my current Employer.

Account Number: _____

_____ I hereby certify that in the event I am terminated or resign my position with Employer prior to any Fondren Orthopedic Group L.L.P., physician or employee providing any service to Patient, I will inform Fondren Orthopedic Group L.L.P., of the change in my employment status prior to receiving any additional services from any Fondren Orthopedic Group L.L.P. physician or employee.

_____ I hereby certify that in the event there is any lapse in the medical benefits provided by the Insurance Company prior to or during the course of treatment by any Fondren Orthopedic Group L.L.P. physician or employee, I will inform Fondren Orthopedic Group L.L.P. of any lapse in the medical benefits provided by the Insurance Company prior to receiving any additional services from any Fondren Orthopedic Group L.L.P. physician or employee.

_____ If applicable, I hereby certify that my son or daughter is currently enrolled as a full time student (however that is defined by said institution) at _____ and that my son or daughter is not for any reason prohibited from receiving benefits under the Insured's policy.

_____ I hereby bind myself to pay Fondren Orthopedic Group L.L.P. on demand no more than the sum, which shall become due to Fondren Orthopedic Group L.L.P. whenever the Insurance Company shall fail to pay the same for any of the following reasons:

(1) The medical benefits provided by Insurance Company were terminated because the Insured was not employed by Employer at the time Patient sought the services of any Fondren Orthopedic Group L.L.P. physician or employee and was therefore ineligible to receive benefits;

(2) Any statement or representation made by the Insured regarding the existence of medical benefits provided by Insurance Company which are later discovered to be false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company;

(3) Any statement or representation made by the Insured regarding the Employer or the Patient (other than medical information), which is later discovered to false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company; and

(4) Any other statement or representation made by the Insured, which is later discovered to false or otherwise inaccurate and prevents Fondren Orthopedic Group L.L.P. from collecting payment from the Insurance Company.

I certify that the information I have provided herein is true and correct to the best of may knowledge and I give permission for Fondren Orthopedic Group L.L.P. to make any necessary inquires to verify the statements made herein. I agree to the obligations contained herein and in the other documents accompanying this certification and I hereby acknowledge and understand the purposes for which this information is needed.

By: _____ Signature

_____ Printed Name

_____ Street Address

_____ City, State and Zip