OSBORNE ORTHOPEDIC GROUP, INC.
612 Kingborough Sq. Ste. 202 • Chesapeake, VA 23320-5054
301 Riverview Ave. Ste 520 • Norfolk, VA 23510-1064
877-269-8434 • Fax 757-548-7191
Tommy Osborne, II, M.D.
www.osborneorthopedics.com • osborneorthopedics@earthlink.net

DATE:

PATIENT:
EMPLOYER:
CLAIM/GROUP#:
SS#/ID#:

I instruct and direct _____ Insurance Company or Legal Representative to pay by check made out to and mailed to the following:

Osborne Orthopedic Group Inc
612 Kingsborough Square #202
Chesapeake, VA 23320-5054

OR

If my current policy prohibits payment to my Provider for reasons such as lack of Provider Participation or Third Party Billing, I also instruct and direct you to pay by check to ME and **mail it to the address as follows:**

PATIENT NAME
c/o Osborne Orthopedic Group Inc
612 Kingsborough Square #202
Chesapeake, VA 23320-5054

This check is for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment of the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the Benefit Payment of Third Party Payment.

A photocopy or PDF file of this ASSIGNMENT OF BENEFITS shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for purpose of payment of services rendered.

I authorize Provider to initiate, on my behalf, a complaint to the INSURANCE COMMISSIONER or GOVERNING STATE BOARD for any reason pertaining to neglect of payment for services or failure to follow my instructions herein.

DATED at _____ this _____ day of _____, 20_____
(time) (day) (month) (year)

_____ _____
Signature of Beneficiary or Claimant Printed Name of Beneficiary or Claimant

Witnessed by _____