

GALESBURG ORTHOPEDIC SERVICES, LTD
834 N SEMINARY ST., SUITE 102
GALESBURG IL 61401
309-342-0194

I hereby authorize payment to Galesburg Orthopedic Services, Ltd. for services rendered and billed to me.

I authorize release of medical information for insurance purposes.

If a workers' compensation claim is denied, we reserve the right to file your charges with your group carrier.

I authorize use of this form on all bills from this office.

I have read, understand, and agree to the Credit Policy Information sheets that were provided to me.

A xerox copy is as good as any original on bills from this office.

DATE: _____

Patient Name – Please print

Signature of Patient or Parent/Guardian