



**ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.**

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***ELIGIBILITY GUARANTEE, FORM***

I, \_\_\_\_\_ hereby certify that I  
Name of Patient/Member/Guardian

have called my insurance plan and have verified the fact that

\_\_\_\_\_ is a provider on my plan.  
Physician Name

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, I am liable for all *charges for services rendered* Also, *-if the above -is* not true, I agree to pay in full for all services received within 30 days of receiving a bill 'from the above note Medical Group or Physician.

\_\_\_\_\_  
Your e-mail address will be used as your  
legal signature if submitted electronically.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness  
Your e-mail address will be used as your  
legal signature if submitted electronically.

\_\_\_\_\_  
Date