Effective 1/1/1999
DUE TO THE CONTINUING CHANGES IN THE INSURANCE INDUSTRY, WE ARE NOW ASKING THAT EACH VISIT TO OUR OFFICE, A COPY OF YOUR CURRENT INSURANCE CARD BE GIVEN TO THE RECEPTIONIST TO BE COPIED, ALONG WITH A CURRENT PHOTO ID (PER RED FLAG LAW) AND A CURRENT REFERRAL IF ONE IS NEEDED. IF YOU ARE UNABLE TO PRODUCE THIS, WE RESERVE THE RIGHT TO RESHEDULE YOUR APPOINTMENT, WHICH WE WILL DO. THANK YOU.

Financial Agreement

Patient Name (please print) _____Date_____

We are medical doctors specializing in orthopedic surgery. This involves treatment of disorders of the bones, joints, muscles and ligaments. In the interest of good medical practice, it is desirable to establish a credit policy. An effective credit policy enables you and the doctor to avoid misunderstandings. We feel it is very important that you understand you are responsible for payment of charges.

If you carry health care insurance, you should remember that the medical services rendered are charged to you and not the insurance company, unless otherwise stated.

If a procedure is not covered by your insurance carrier and you still request to have procedure done, we will bill your insurance as a courtesy, and if it **denied for any reason** you will be responsible for the amount agreed upon by you and the provider of service. If an insurance claim is filed in your behalf and a balance due, you will receive a statement each month. Unfortunately, this office cannot accept responsibility for collecting an unpaid insurance claim or for negotiating a settlement on a disputed claim.

If you are uninsured, payment is expected when services are rendered. You are responsible for payment of your account. In cases of severe hardship, reasonable payment programs can be arranged by contacting our bookkeeping department.

Assignment of Benefits

I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to Dr. _____. Payment is authorized upon your receipt of an itemized statement of services. I also authorize my provider of service to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Records Release Authorization

I herby authorize Dr. _____ to release to my referring physician, insurance company, attorney, or legal guardian, any information, including diagnosis and records or treatment, concerning my medial history and orthopedic care. Any study data collected may be used in any medical publication.

Medicare Patient Signature Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claim.

I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made to Dr. _____ on any bills for services furnished me by that physician during the period from _____ to December 31, 20_____.

Privacy Policy Acknowledgement

I acknowledge I have access to, have reviewed or have received a copy of this office's Notice of Privacy Practices.

Acknowledgement not obtained because: ___ Patient refused to sign ___ Other _____

I have read and agree to all of the above _____

Patient/Guardian **Date**