ADVANCED ORTHOPAEDICS AND SPORTS MEDICINE-THERAPY SERVICES
PATIENT FINANCIAL POLICY

FINANCIAL RESPONSIBILITY: In return for services rendered to me at Advanced Orthopaedics and Sports Medicine therapy services, I promise to pay Advanced Orthopaedics and Sports Medicine in accordance with bills or invoices presented according to the regular rates and terms of this clinic. Unless other arrangements have been made in advance by either you or your health insurance full payment is due at the time of service.
For your convenience we accept VISA, MasterCard, American Express and Discover.

- Prior arrangements have been made with many insurers and health plan to accept an Assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment or deductible at the time of service. *This office's policy is to collect co-payment when you arrive for your appointment.*
- If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send the claim for you as a courtesy. Consequently, the charges for your care and treatment are your full responsibility if your insurance company denies payment to us. You will be required to sign a direct pay authorization and medical lien at the time of treatment.
- In an event that your health plan determines services as to be " not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Should you not have an insurance you are determined to be a self-pay patient. Payment arrangements will be made with our financial manager and payment will be made prior to services being rendered.
- **MINOR PATIENTS**: For all services rendered to minor patients, we will look to adult accompanying the patient and the parent or guardian with custody for payment.
- **MEDICARE PATIENTS**: I acknowledge that as per Medicare regulations, I do not have any outpatient therapy benefits if I am currently receiving HOME HEALTH THERAPY. If I am currently receiving home health, my outpatient services will not be reimbursed by Medicare and I will be responsible for all charges submitted by this facility. I have also been informed of the therapy cap and provided with written copy of the same.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS:
In consideration of services rendered, I hereby irrevocably assign and transfer to the AOSM clinic for myself and my dependents, all rights, title and interest in the benefits payable for services, rendered by the AOSM clinic provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for the purpose of granting the AOSM clinic an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for this outpatient treatment, but shall not be construed to an obligation for the clinic to pursue any such rights or recovery. I also hereby authorize and direct all insurance company(ies) under which I am insured to pay directly to the AOSM clinic, all benefits due under said policy(ies) by reason of services, rendered therin. I will pay the clinic for all the charges incurred, or alternately, for all charges in excess of the sum paid by the said policy(ies).
I also irrevocable assign to the AOSM clinic all rights, total and interest in benefits payable out of any third party action against any other person, entity or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover. Each person signing the admission consent is financially responsible for charges not collected by this agreement.

RELEASE OF INFORMATION:
To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the clinic and patients clinicians to disclose my (patients) health care information (without my/patients written authorization) to any person, Social Security Administration, Insurance or Benefit Payor, Health Benefit Plan , Workers Compensation Carrier medical researchers, audit committees, care evaluators and applicable state and federal agencies which is, or may be liable to all or a portion of the clinics or treating clinicians charges and to complete claims on behalf of the patient. I understand that my (patients) health care information will not be provided (without special written authorization from me/patient) to any person including next to kin, close personal friends, florists, delivery personnel or physicians who are not currently treating me (the patient). My (patients) name and addresses are not considered health information and may be disclosed by the clinic as necessary.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

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Printed Name of the Patient/Guarantor (for minors)	Signature of patient (patients representative)	Date