ADVANCED ORTHOPEDICS AND SPORTS MEDICINE INSTITUTE, PC

A CENTER OF EXCELLENCE FOR BONE AND JOINT CARE

FINANCIAL POLICY AND INSURANCE AUTHORIZATION

I request that payment of authorized Medicare and/or other Insurance Company benefits be made to me on behalf of Advanced Orthopedics and Sports Medicine Institute, PC for any services furnished to me by this party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize my holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration, its intermediaries or carrier, or any other insurance company any information needed for this or related Medicare and/or other Insurance Company claim. If Item 9 of the HCFA-1500 Claim form is completed, my signature authorizes releasing of information to the insurer or agency shown. In Medicare and/or other Insurance Company assigned cases, the Company as the full charge, and **the patient is responsible for the deductible, co-insurance and non-covered services**. Co-insurances and deductibles are based upon the charge determination of Medicare and/or other Insurance Company.

If Advanced Orthopedics and Sports Medicine Institute does not have a contract with my insurance company, all professional services rendered are charged to myself, the patient or parent/guardian, who is responsible for all fees. It is customary to pay for services when rendered, unless other arrangements have been made. Acceptable forms of payment are: cash, check, Visa, MasterCard, Discover or American Express. In the event I fail to pay for services rendered, my account will be turned over to collection. I will be charged a $35 fee for any account turned over to collection, as well as all fees relating to collection procedures.

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment, directly or indirectly; obtain payment from third-party payers; and conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your HIPAA Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its HIPAA Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the HIPAA Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or heath care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

DESIGNATION OF DISCLOSURE

I agree that Advanced Orthopedics and Sports Medicine Institute, PC may disclose my health information to a family member, close personal friend, or other caregiver, since such person is involved with my healthcare and/or payment relating to my healthcare. In that case, Advanced Orthopedics and Sports Medicine Institute, PC will disclose only information that is directly relevant to the person's involvement with my healthcare and/or payment relating to my healthcare.

I designate the following persons listed below as a person involved with my healthcare and/or payment:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone	☐ Detailed Message	☐ Call back Number Only
☐ Work Telephone	☐ Detailed Message	☐ Call back Number Only
☐ Cell Telephone	☐ Detailed Message	☐ Call back Number Only

☐ Mail to Home Address

☐ Mail to Work Address

Patient's Name _____

Signature _____ Printed Name _____ Date _____

(Patient/Parent/Guardian) (Patient/Parent/Guardian)

POND VIEW PROFESSIONAL PARK

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