ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

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FINANCIAL POLICY AND INSURANCE AUTHORIZATION

I authorize Orthopaedic, Sports Medicine and Rehabilitation Center, PA ("OSMRC") to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, or to any other insurance company for which I or my dependents or insurance beneficiaries is/are covered insureds, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare and/or other third-party insurance company benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to OSMRC. If my insurance carrier will not assign benefits to OSMRC, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan.

We are providers for some insurance plans and we will bill your insurance company directly. Most plans require co-payments and/or deductibles and co-insurance that are due at the time of service.

If we are not a participating provider with your insurance plan, or you do not have insurance, payment is expected in full at the time of service.

If your visit is a result of a work injury or motor vehicle accident, you must provide us with the following information prior to your visit: insurance carrier, claim number, adjuster's full name and phone number, and date of accident. If your visit is not authorized by this insurance carrier, you will be fully responsible for services rendered.

I understand that I am responsible for all deductible, co-payment, co-insurance and/or charges for all non-covered services. 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. There is a $20 administration fee for any returned check. In the event I fail to pay for services rendered, when payment is due, my account will be turned over to collection.

Please feel free to contact our Billing Office if you have any questions. We are happy to answer your questions or to provide additional information.

I understand and acknowledge the financial policy and insurance authorization terms stated above.

_____ _____

Patient's Name **Date**

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Signature (Patient/Parent/Guardian)