ATLANTIC ORTHOPAEDICS, P.A.

PATIENT FINANCIAL RESPONSIBILITY FORM

We appreciate you choosing Atlantic Orthopaedics, P.A. as your healthcare provider. In order to provide you with the highest quality healthcare, we ask that you help us by reading the following and sign to acknowledge that you have been informed of our Patient Financial Policies.

PATIENT FINANCIAL RESPONSIBILITIES

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of their treatment or care.
- The patient is responsible for knowing the terms of their insurance and for providing us with complete and accurate billing information including, but not limited to:
    - Most current and up to date insurance card
    - Authorization numbers
    - Referral forms
- The patient is responsible for providing us with correct and up to date insurance information and will be responsible for any charges incurred if the information provided is not correct or up to date. To benefit the patient, a copy of the insurance card must be presented at each visit.
- If a patient is uninsured, they are responsible for keeping up with payments and will pay when service is rendered.
- Patients are responsible for the payment of co-pays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance. The payment is due at the time of the service. We accept cash, checks and most credit cards.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Atlantic Orthopaedics. These charges include, but may not be limited to:
    - Returned checks
    - Extensive telephone consultations
    - Copying and distribution of medical records
    - Completion of forms
    - Costs associated with collection of patient balances , including service charges and attorney or collection fees

PATIENT AUTHORIZATION

- With my signature below, I authorize Atlantic Orthopaedics, (the physicians, staff and hospitals associated with the practice) to release medical and other information acquired in my examination and treatment to the necessary insurance companies and third party payers, and/or other physicians/healthcare entities required to participate in my care. This information may include, but is not limited to, diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.
- With my signature below, I authorize the assignment of financial benefits directly to Atlantic Orthopaedics, and any associated healthcare entities for services rendered as allowable under standard third party contracts.
- With my signature below, I authorize Atlantic Orthopaedics communication by mail, answering machine, and/or e-mail according to the information I have provided.
- I understand I can make appointments only once my unpaid balance has been paid or payments are being made.

I have read, understand and agree to the provisions of the Patient Responsibility Form

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Signature of Patient/Guardian Date

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Printed Name of Patient/Guardian Date of Birth

Waiver of patient Authorization-I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

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Signature of Patient/Guardian Date