Orthopedic Healthcare Associates, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that health care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices is available in our waiting area and provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge that you have received a copy of our Notice and agree to its terms.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient or patient's representative:_____

Relationship to the patient:_____

Please return this acknowledgement before leaving today. If you have any questions please contact our privacy officer.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. We accept **Cash, Check, Visa, and MasterCard.**

INSURANCE

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Medical Care providers, our relationship is with you, our patient, not with your insurance company. However, as a courtesy to you, we will bill most insurance companies. In order for us to accurately bill, you will be asked to update your information at each visit.

If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If you are unable to pay your co-pay at the time services are rendered, you may be asked to reschedule your appointment. If you do not have health insurance coverage, payment is due at the time services are rendered unless the office manager has approved special arrangements.

Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. The patient is responsible for payment of the account within thirty days of receipt of the statement. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise it is recommended that a payment plan be initiated. We encourage you to contact a billing specialist in our office for assistance in the management of your account.

Secondary insurance claims will be submitted one time as a courtesy to the patient. However, the patient will remain responsible for the balance except in the instances where our practice is in contractual arrangement with the secondary insurance. If payment is not received from the secondary insurance, the balance will become the responsibility of the patient.

IN THE EVENT WE ARE FORCED TO SUBMIT A DELINQUENT ACCOUNT TO A COLLECTION AGENCY, THERE WILL BE A 33% COLLECTION FEE ADDED TO THAT ACCOUNT.

Thank you for understanding our financial policy. Please let us know if you have any questions.

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 such terms may be amended from time to time by the practice.

_____ ____/_____/_____
Patient/Parent/Guardian Date

PAYMENT ARRANGEMENTS (Check one)

_____Pay my balance in full at the time of service
_____Make my payment arrangements prior to services being performed
_____Pay my balance in full upon receipt of first statement

AUTHORIZATION FOR PAYMENT

I authorize the release of medical information necessary to process my medical claims. I authorize payment of medical benefits and / or surgical benefits to be paid directly to Drs. Majestro, Molina, Ede, and I agree to promptly pay any unpaid balance.

Signature:_____Date:___/___/_____