WE APPRECIATE THE OPPORTUNITY TO SERVE YOU
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENT:

It is the policy of Mid-Island Orthopedics and Sports Medicine, PC to require payment of all office charges at the time they are given, unless prior arraignments have been specifically made and are documented accordingly. All accounts with an open balance over 30 days will be charged a rate of one and one-half percent (1 1/2%) per month or a minimum of $2.00 per month. A $10.00 monthly billing fee will be automatically charged to any account that receives more than one statement; this is in addition to any interest charges and/or co-pay fees.

Co-pays are due at the time a patient is seen. Any co-pay not paid at the time services are rendered, without agreement from management, will accrue a $10 billing fee.

Appointments are made with every effort to accommodate patient's scheduling limitations and requests. As such, we request that all appointments be made with your own schedule in mind. In the event an appointment cannot be kept, you must cancel the appointment 24 hours or more prior to your appointment. **Appointments that are either not kept or not cancelled in a timely manner will be subject to a $25.00 fee.**

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 25% of said unpaid balance. Settlement agreements and courtesy offers are only applicable to patient accounts still under office management. In the event an account is transferred to the Collection Attorney of Record, the guarantor will be responsible for the full balance of charges per the Explanation of Benefits provided by the Insurance Carrier issuing payment for the patient's care. If Mid-Island Orthopedics and Sports Medicine, PC does not participate with your Insurance Carrier, per the Explanation of Benefits, the guarantor is responsible for the full billed amount minus any payments received and accepted by Mid-Island Orthopedics and Sports Medicine, PC.

INSURANCE POLICY:

Insurance provides reimbursement on allowed medical charges. As a courtesy, we will provide an itemized statement you may send to your insurance company for payment. we will be happy to submit most insurance carriers, if you have provided the following: Name of the Insurance Carrier to be billed, Address of the Insurance Carrier, the Policy Identification Number, the Group number (if applicable), the policyholder's Employer Information and other pertinent information needed to complete a HCFA 1500 Medical Claim Form required by all insurance carriers to consider charges for payment. **The guarantor is responsible for all co-pays, co-insurance, deductibles and any charges not covered by the insurance policy.** Please understand that we cannot, as a third party, become involved in any prolonged negotiations. The balance of the patient's account is the guarantor's responsibility. In the event a balance cannot be paid in full, it the guarantor's responsibility to make arraignments with Management to pay the balance. If arraignments are not made, the guarantor will then be sent to the Collection's Attorney.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize Orthopedics and Sports Medicine, PC and their assigned representatives to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal and at any time the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I, the undersigned, have read the above and accept responsibility for this account in full.

Signed: _____ Date: _____
(Patient or Parent / Legal Guardian)

Signature of Guarantor if Different than Patient: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

Is there anyone we may speak with about your Medical Information or Billing matters on your behalf?

( ) No, speak only with me
( ) Yes, you may speak with: _____.