

# ARTHRITIS & SPORTS

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## ORTHOPAEDICS & PHYSICAL THERAPY

### “NOTICE OF PRIVACY PRACTICES”

#### Acknowledgement of Receipt

By signing this page, I acknowledge having received the HIPAA notice that describes how medical information about me may be used and disclosed.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

I, \_\_\_\_\_, hereby allow Arthritis and Sports Orthopaedics to release my private healthcare information to (Spouse, Children, Other): \_\_\_\_\_, \_\_\_\_\_.

#### ASSIGNMENT OF INSURANCE BENEFITS

As the patient whose name appears below, I hereby authorize Arthritis & Sports Orthopaedics, P.C. to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Arthritis & Sports Orthopaedics, P.C. for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Arthritis & Sports Orthopaedics, P.C., all co-insurance co-pays and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Arthritis & Sports Orthopaedics, P.C. Further, I will be responsible for payment of charges not covered by my insurance plan.

Payment is requested at the time services are rendered. If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of insurance carrier. Arthritis & Sports Orthopaedics, P.C. will bill charges to the primary and/or secondary insurance carrier, and Arthritis & Sports Orthopaedics, P.C. will bill the remaining amount to the patient. Any balance due, for whatever reason, i.e. co-payments, failure to have proper referral, denial of worker's compensation benefits, is the patient's responsibility. Payment for charges which are the patient's responsibility are to be paid within 30 days. The patient and guarantor signing below accept responsibility for payment. Should the patient's account be turned over for collections/and or an attorney for payment due, the patient and/or guarantor shall pay any collection costs and 33% attorney fees. The patient and the guarantor agree to be responsible for and to pay interest of 18% on any unpaid balance due to Arthritis & Sports Orthopaedics, P.C. The staff of Arthritis & Sports Orthopaedics, P.C. will gladly assist you with any aspect of this policy

#### Cancellation Policy (effective March 1,2003)

If you are unable to keep your appointment we require 24 hours notice of cancellation in order to avoid a \$35 fee

\_\_\_\_\_  
PATIENT SIGNATURE

**PAYMENT GUARANTEED**

IF PATIENT IS A MINOR, PLEASE SIGN AND FILL OUT GUARANTOR INFORMATION

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GUARANTOR SIGNATURE