

ORTHOPEDIC GROUP, INC.

FINANCIAL AGREEMENT

The doctors and staff of the Orthopedic Group Inc. welcome you as a patient and are pleased that you chose us to provide your medical care. We have advised you that we do not participate in all insurance programs and that certain services, in some cases, are not covered by insurance. We reserve the right to perform services and utilize certain professional staff to assist us in your care regardless of your insurance coverage.

Our office policy is to receive payment at the time services are rendered. We encourage you to ask questions and make sure you fully understand what your responsibilities are, because you are ultimately responsible for paying for all the services you receive. We are available to explain some of the general parts of how your insurance will cover the services provided by our practice, but only your insurance company will have the specifics of how your plan works. We recommend that you contact them for details on your specific coverage.

A finance charge of 1¼% per month (15% annually) may be charged on all past due accounts and a \$25 fee will be assessed for any returned check. In the event of non-payment of an account, you understand and agree that you will be responsible for all collection costs, including reasonable attorney fees, incurred for the collection of said balance.

GENERAL CONSENTS/AUTHORIZATIONS

I hereby give Orthopedic Group, Inc. (OGI) consent for those services deemed medically necessary and appropriate by the attending provider.

I request that payment of authorized Medicare, or any other insurance benefits be made on my behalf to Orthopedic Group, Inc. for any services provided to me by that group. I understand that any holder of medical information about me, may release any information to the Health Care Finance Administration (HCFA) and its agents, in order to facilitate reimbursement for services rendered. I authorize OGI to release information to all parties and/or their representatives listed on my Patient Information Sheet or that may be required to provide or pay for services rendered. In addition, I hereby authorize OGI to obtain Medication History related to me, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

I understand that the above consent/authorizations do not guarantee payment/reimbursement nor does it release me from any obligation and responsibility for all outstanding charges not covered as a result of, but not exclusive to: co-payments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services.

I understand that it may be necessary to use a photocopy or facsimile of this assignment and that it is to be considered as valid as the original.

PATIENT'S RESPONSIBILITY FOR MEDICAL CARE

During the course of your orthopedic evaluation and management, your doctor may suggest that you have certain tests done, be evaluated by a physician of a different specialty or return to this office on a future date for re-evaluation. In consideration of this, and your health, we ask that you keep all scheduled appointments and associated commitments. If you have any questions concerning the recommended management plan, please be sure to have them addressed during your visit, or by phone, should questions come up after your visit. The continuity of your care often depends on your full cooperation and open communication. If, for some reason you cannot proceed with your doctor's recommendations, please let us know as soon as possible. Your doctor relies on your honest and complete feedback and will respect your decision. In regards to results from your visit or completed tests, we will call you when we have the results but please feel free to call this office to request the information. It is important that you understand the consequences of not following through with recommended testing or scheduled appointments. The field of medicine, especially Orthopedic Surgery, often involves problems, which, if not properly addressed, can be life threatening. Your signature below acknowledges your understanding of the importance of proceeding with the management plan as recommended and the subsequent consequences of not doing so.

Patient/Guarantor:

(PRINT NAME) _____ (SIGN) _____ DATE: _____

Individual's Signature indicates that they have read the above statement and agree to accept its terms and conditions.