CENTER FOR ORTHOPAEDICS FINANCIAL POLICIES

ASSIGNMENT OF BENEFITS: PLEASE REVIEW AND SIGN BELOW

- I hereby authorize direct payment of medical benefits to Center For Orthopaedics for services rendered.
- I understand that I am financially responsible for any balance not covered by my insurance.
- I also understand that by providing Center For Orthopaedics with insurance information, financial responsibility is ultimately mine and that insurance is only a form of payment. I understand I must abide and adhere to my health insurance policy rules and requirements especially with respect to referrals and in-network providers.

Some of our physicians do not participate in the following insurances. Please review this list and verify if the physician you are scheduled with participates in your plan prior to seeing that physician.

GHI NJ FAMILY CARE AMERIHEALTH QUALCARE HMO & POS(PENDING ENROLLMENT)
MEDICAID AMERICHOICE HEALTHNET BEECHSTREET EMPIRE NY

Patient/Guardian Signature_____DATE_____

******PAYMENT POLICY******

PLEASE READ AND SIGN THE SECTION BELOW THAT CORRESPONDS TO YOUR INSURANCE

- **HMO/PPO PLANS**

We participate with most HMO and PPO plans. You are responsible for providing your insurance card, a form of identification and a referra if one is required. You must verify with your insurance that the physician you are scheduled with is in your network. If a valid referral is no presented at the time of your visit you will be held financially responsible for that visit. Please be prepared to pay your required copayment and/or any outstanding balance on your account on the day of services. We will assist you in tracking your visits, however you are responsible to know how many visits are available to you and how many you have remaining. Any visit not covered with a referral will become your financial responsibility. We will make every attempt to assist you whenever possible.

If your plan requires a referral please circle the appropriate response:

- My insurance requires a referral: YES NO
- I am providing a valid referral for today's visit: YES NO

OR

- I have chosen to be seen without a valid referral and have agreed to pay for this visit in full: YES NO

Verified by: _____(initials of front desk representative)

Patient/Guardian Signature_____DATE_____

- **MEDICARE**

Our participation with Medicare includes Physicians and X-ray services. Medicare patients are responsible to pay for some supplies we provide on the day of service. Medicare patients are also responsible for an annual deductible and a 20% coinsurance when applicable.

Patient Signature_____ DATE_____

- **WORKER'S COMPENSATION/NO FAULT(MOTOR VEHICLE ACCIDENT)**

You are required to bring ALL of your insurance information with you for your visit. This includes the Claim number, Adjustor's name, phone number, fax number and billing address for medical claims. For No Fault insurance a second insurance policy can be billed to possibly pay for any balances, Please provide your medical insurance for this purpose. If you do not have medical insurance then you are responsible for any balances incurred with your No Fault insurance.

Patient/Guardian Signature_____DATE_____

- **OUT OF NETWORK/SELF PAY**

If Center For Orthopaedics does not participate with your insurance or if you have no insurance, payment will be required at the time of service. We will provide the necessary billing forms for you to submit to your insurance if applicable.

Patient/Guardian Signature_____DATE_____