Ortho Rhode Island

FINANCIAL AGREEMENT

The doctors and staff of Orthopedics Rhode Island 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. If you are not prepared to make your co-pay or other patient financial responsibility amount, you may incur additional fees or your visit may be re-scheduled. 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 of 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. If you are not familiar with your coverage, we recommend you contact your insurance carrier directly.

You will be required to follow all registration procedures, which may include updating or verifying personal information and presenting verification of current insurance at each visit. Your card or other insurance verification must be on file in order for your insurance to be billed. If we do not have your insurance card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service.

A finance charge may be placed on all past due accounts and a $25 fee will be charged on any returned check. In the event of nonpayment of an account, understand 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 Orthopedics Rhode Island 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 Orthopedics Rhode Island 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 ORI 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.

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 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. 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) :_____(SIGN)_____DATE:_____

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