

Dear Patient – Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company or health care provider.

Patient ID# _____ Group Name & # _____

Patient's name _____ Subscriber's name _____

Full name of spouse _____ SS# _____

Spouse's empl: _____ Spouse DOB: _____

Is your spouse covered by any health insurance? Y N Name of carrier _____

ID# _____

Is your problem covered by any other insurance Y N Name of carrier _____

ID# _____

To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes _____ insurance carrier, any & all information concerning claims filed by me or on my behalf to another insurance carrier.

SIGNATURE _____ Date _____

Please note that if your insurance contract contains a pre-existing health clause, they may not pay for the services performed by our office. If payment for services is denied by the insurance carrier, you will be responsible for payment. If our claim is held up for payment by your carrier for investigation of a pre-existing condition for longer than 90 days, you will be responsible for payment of the entire bill. By your signature, you have read our protocol for pre-existing condition clauses.

Signature: _____

PATIENT LIABILITY AGREEMENT

I understand that I am financially responsible for all bills incurred while under the care of Associated Orthopaedics. In the event that my account is not paid in full, I shall be liable for any and all costs of collections, including, but not limited to an additional 35% fee* (*as defined by the balance of the bill due divided by .65) of the outstanding balance if my account is forwarded to a collection agency for collection; and, if my account is forwarded to any attorney for legal proceedings. I agree to be liable for an additional attorney fee of 50% of the outstanding balance. By signing below, I hereby indicate that I have read this agreement, understand the terms of this agreement and agree to the terms of this agreement.

Patient/Guardian (Print Clearly)

Patient/Guardian Signature

Date Signed _____