ORTHOPAEDIC SURGERY AND REHABILITATION ASSOCIATES, PC

FINANCIAL POLICY

Thank you for choosing Orthopaedic Surgery and Rehabilitation Associates for your Rehabilitation needs. Our Team of professionals is committed to providing you with the highest standard of quality care leading to a successful recovery.

Please understand that reimbursement of our charges for the services you receive is part of your treatment. This is a financial responsibility on your part that obligates you to ensure payment in full of your incurred charges. As a courtesy to you, we will verify your coverage where applicable, and bill your insurance carrier on your behalf (based on the information you have provided us). Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract.

You are responsible for payment of any deductible and co-payments as determined by your contract with your insurance carrier. All co-payments and deductibles are due prior to treatment. In the event your insurance coverage changes to a plan where we are not participating providers, please refer to the above paragraph. If you receive payment from the insurance carrier for services provided by Orthopaedic Surgery & Rehabilitation Associates, PC, it shall be reimbursed to Orthopaedic Surgery and Rehabilitation Associates, PC at the time of receipt.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, you will be responsible for a $40.00 charge per missed appointment. Please note that this fee is not covered by your insurance carrier. Please help us serve you better by keeping scheduled appointments.

I have read the Financial Policy and understand I may be financially responsible for charges incurred at Orthopaedic Surgery and Rehabilitation Associates, PC for treatment or as a result of exhausted benefits.

______________________________________________            _________________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY                                                             DATE

______________________________________________            _________________
SIGNATURE OF CO-RESPONSIBLE PARTY                                                                               DATE

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Orthopaedic Surgery and Rehabilitation Associates, PC through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures related to my presenting dysfunction.

I further authorize Orthopaedic Surgery and Rehabilitation Associates, PC to furnish information to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

______________________________________________            _________________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY                                                             DATE