Orthopedic Healthcare Associates, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that health care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices is available in our waiting area and provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge that you have received a copy of our Notice and agree to its terms.

**_____ _____

Signature of patient or patient's representative Date

Printed name of patient or patient's representative:_____

Relationship to the patient:_____

Please return this acknowledgement before leaving today. If you have any questions please contact our privacy officer.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care and building a successful physician-patient relationship with you. Your clear understanding of our financial policy is important to our professional relationship.

The patient is expected to present an insurance card at each visit. **All co-payments, deductibles and past balances are due at the time of check-in**. We accept **Cash, Check, Visa, MasterCard, Discover and AmExpress.**

If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If you are unable to pay your co-pay at the time services are rendered, you may be asked to reschedule your appointment. If you do not have health insurance coverage, payment is due at the time services are rendered.

We must emphasize that as Medical Care providers, our relationship is with you, our patient, not with your insurance company. As a courtesy to you, we bill most insurance companies. However, you are responsible for any amounts not paid by your insurance company. It is imperative that we have complete and accurate insurance information from you in order to bill your insurance company. Failure to provide complete insurance information may result in patient responsibility for the entire bill.

A detailed statement of charges will be sent to you. Payment in full is due within 30 days. To avoid misunderstandings regarding your bill, please call our office with any questions or concerns. Accounts that are 90 days past due are referred to a collection agency.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice.

**_____ ____/_____/_____

Patient/Parent/Guardian Date

AUTHORIZATION FOR PAYMENT

I authorize the release of medical information necessary to process my medical claims. I authorize payment of medical benefits and / or surgical benefits to be paid directly to Dr. Majestro or Dr. Molina, and I agree to promptly pay any unpaid balance.

Signature:_____Date:___/___/_____