

Signature on File/Assignment of Benefits/Financial Responsibility

Print Patient Name: _____ Date of Birth: _____

Payments and Financial Responsibility Agreement (All Patients):

*In order to help you determine your responsibility toward payment for services, please read below.
Please notify this office if the status of your insurance changes.*

I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment. I agree that in return for the services provided by Martin & Suhey Orthopedics, P.C., I will pay my account at the time of service or I will make financial arrangements satisfactory to Martin & Suhey Orthopedics. If my account becomes delinquent, it may be sent to a collection agency. If a co-payment or deductible is designated by my insurance company or health plan, I agree to pay it at the time of service. I understand that if I come to my appointment unprepared to pay, my appointment may be rescheduled or a billing fee of \$10 will be incurred in addition to the co-payment. I understand that I am responsible for payment of my bill. I am aware that there will be a \$20 charge for returned checks.

Patients with Medicare:

I request payment of authorized benefits to be made on my behalf to Martin & Suhey Orthopedics for services rendered to me. I authorize any holder of medical information about me to release to Center for Medicare and Medicaid Services any information needed to determine benefits payable for related services. I understand that by my signature below I am requesting payment be made and authorizing release of medical information necessary to pay the claim. My signature below authorizes release of information to secondary insurer to my Medicare coverage. Martin & Suhey Orthopedics accepts the Medicare determination of allowable charge. I am responsible for deductibles, coinsurance and non-covered services.

I understand that if a Medicare supplemental policy or other secondary health insurance is indicated, my signature authorizes release of information to the insurer indicated. I request payment of authorized secondary insurance benefits be made on my behalf to Martin & Suhey Orthopedics, P.C. If paid to me I will forward same to Martin & Suhey Orthopedics, P.C.

Patient Signature: _____ Date: _____
(or Authorized Party)

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature

Date