CHART #: _____

Signatures and Authorizations

PATIENT NAME: _____ DOB: _____-_____-_____
LAST FIRST MI

Insurance Authorization and Assignment

X_____ (initial) I hereby authorize Capital Area Orthopedic Associates (CAOA) to apply for benefits on my behalf or my dependents for covered services rendered. I request payment from my insurance company be made directly to CAOA. I authorize the release of any necessary information, including Protected Health Information, for this or any related claim, to requesting insurance company.

Patient/ Subscriber Financial Responsibility

X_____ (initial) I understand that I am financially responsible for all services rendered by CAOA, regardless of insurance coverage, whether or not there was an accident with another party at fault, and regardless of whether or not workman's compensation carrier denies my claim. I understand that all co-pays and deductibles are due at the time of my visit. I understand and agree that I accept responsibility for paying CAOA's bill, including Durable Medical Equipment (DME), supplies and other non-covered services by insurance.

I understand that I am responsible for charges incurred for the collection of my account. I understand that an account balance outstanding for more than 30 days is considered delinquent, if unresolved after 60 days, delinquent balances will incur a $25 collection fee and may be turned over to our account resolution specialist for collection. I understand that I am responsible for any deductible and co-insurance balance.

Acknowledgement of Receipt of Notice of Privacy Practices

X_____ (initial) I have received a copy of the CAOA Notice of Privacy Practices, either via hard copy, CAOA website or display in CAOA waiting room. I understand I can request a copy for my records.

Authorization to Obtain Medication History

X_____ (initial) I hereby authorize Capital Area Orthopedic Associates to obtain Medication History related to the patient above from Pharmacies or other healthcare providers for treatment purposes.

Authorization to Release information

X_____ (initial) I authorize the release of medical information to my primary care or referring physicians and as necessary to process prescriptions. I authorize transmission of medical information by fax.

CHART #: _____

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Authorization to Verbally Discuss PHI

X_____ (initial) I hereby give permission for representatives of CAOA to discuss my Protected Health Information (PHI) with the following individual:

_____ _____

Name of Individual Identification (DOB, SSN, Other Means to Verify)

This authorization will stay in effect until you notify us otherwise.

Referrals

X_____ (initial) I understand that if my insurance policy requires a referral that it is my responsibility to bring the referral with me to my appointment. I understand that I cannot be seen without a referral (if required by insurance) and I will have to reschedule my appointment if I do not have one. I am responsible to obtain subsequent referrals for continued visits.

Self-Pay Patients

X_____ (initial) I understand that if I do not have insurance or if I do not have my insurance card with me at the time of registration, I will pay a $175 fee towards anticipated services. Additional fees may be assessed at the time of check-out.

Outstanding Balances

X_____ (initial) I understand that if I have an outstanding balance I will not be able to make an appointment until the balance is paid in full or a payment plan has been setup.

No Show Fee

X_____ (initial) I understand that if I do not give CAOA at least a 24 hour notice to cancel my appointment, I will be charged a $25 no show fee.

CHART #: _____

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Fees

X_____ (initial) I understand that CAOA charges the following fees:

- Returned checks - $25
- No Show - $25
- Copies of Medical Records - $25
- Copies of Itemized Bill - $15
- Insurance or Work Forms - $10
- VA Disability Forms/Packet - $150

Certification of Information Given to CAOA

X_____ (initial) I certify that the information I have given to CAOA with regards to my insurance coverage as well as my medical history is true and accurate. I understand that it is my responsibility to notify CAOA of any changes to my insurance coverage or medical history.

We are very happy that you have allowed us the opportunity to assist you with your orthopedic needs. Please refer to our website for more information regarding CAOA and our policies. The following information can be found on the website under "Patient Forms" or you can obtain a copy from our front desk:

- Billing Policies
- Insurance Billing
- Notice of Privacy Acts
- Prepare for Your Visit
- Workman's Compensation

I have read and understand all of the above policies.

_____
Printed Name

_____ _____
Signature of Patient/Guardian Date