

ALLIED ORTHOPAEDICS

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FINANCIAL POLICY & CONSENT FOR TREATMENT

Thank you for choosing us as your Orthopedic Health Care Provider. The following is our Financial Policy and Consent for Treatment. Our main concern is that you receive the proper optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign our Financial Policy and Consent for Treatment as well as complete our Patient Information Form prior to having your exam. **ALL PATIENTS** must have one **FORM** of picture identification i.e.: valid driver's license.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Allied Orthopaedics and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents, employees of Allied Orthopaedics and the medical staff (or their designees) as in their professional judgment may deem necessary. I acknowledge that no guarantee has been made to me as to the result of examination or treatment in this clinic.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Allied Orthopaedics of all insurance benefits, to which I would otherwise be entitled for these services. I understand that I will be obligated to pay for any service not paid for by my insurance including (but not limited to) services that are deemed to be medically necessary. I accept financial responsibility to Allied Orthopaedics for 100% of the charges. I will pay any legal fees incurred by Allied Orthopaedics in collecting this account.

CASH PATIENTS: Payment for services is due at the time services are rendered. We will accept a \$300.00 down payment with set monthly payment arrangements. **NO EXCEPTIONS.** We accept cash, checks, Master Card, or Visa. If payment is not able to be made at the time of appointment please reschedule, until you are able to make payment.

INSURED PATIENTS: Must have Insurance Cards, and/or Insurance Forms. All Co-Pays and Deductibles are due at the time services are rendered, **NO EXCEPTIONS.** All insured patients are required to sign the assignment of benefits for payment from the insurance company.

FEES: RETURNED CHECKS: Will be subject to a \$20.00 fee, for processing. **CANCELLATIONS, please contact our office within a reasonable time to cancel your appointment, preferably 24 hours notice.** Unpaid Balances after 60 days will be assessed a 25% APR late fee.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us, and we appreciate the opportunity to serve you.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I HAVE READ IT, UNDERSTAND ITS CONTENTS AND VOLUNTARILY AGREE TO ITS PROVISIONS AND HEREBY CONSENT TO ALLIED ORTHOPAEDICS.

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| Patient's Signature: | | Witness's Signature: | |
| Date: | Time: | Date: | Time: |

Responsible Person (if patient is unable to sign or is a minor)

| | | | |
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| Parent/Guardian Signature: | | Witness's Signature: | |
| Date: | Time: | Date: | Time: |