

**ACKNOWLEDGMENT OF OFFICE POLICIES RELATING
TO PAYMENT OF MEDICAL EXPENSES**

Initial

 X If you have a fracture we will be billing a fracture management code to your insurance. This entitles you to 90 days of follow-up care in which the office visit will be at no charge to you or your insurance. Casting supplies and x-rays are not included during these 90 days and are an additional charge. Please advise our office if your care will be followed up by an orthopaedist in another area.

 X I understand and acknowledge that it is my responsibility to know and understand the nature and extent of any insurance coverage that may apply to medical bills for this claim. This may include any available health insurance, Medicare, Medicaid, automobile, liability or other insurance benefits. Specifically, I understand that it is my responsibility to know and be responsible for any DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, ETC., and further acknowledge that it is not the responsibility or duty of the The Center for Bone and Joint Disease to determine this information.

 X I understand and acknowledge that all co-payments and/or co-insurances are to be paid at the time that medical services are provided. I further understand that my account may be turned over to a collections agency and/or an attorney for collection. In that event, I will be responsible for reasonable attorney fees and costs that may apply and which are incurred in collection of the account.

 X In the event that my check is returned for insufficient funds, I am aware that the following fees (in addition to the amount of the bill) will apply in accordance with Section 832.07, Fla Stat.:

- \$25.00 if the amount of the check does not exceed \$50.00
- \$30.00 if the amount exceeds \$50.00 but does not exceed \$300
- \$40.00 if the amount exceeds \$300.00 or 5% of the amount of the check, which ever is greater.

 X I have been informed that The Center for Bone and Joint Disease will not retroactively file to any type of Medicaid for any service for this injury.

 X I understand that a minimum fee of \$30.00 is charged for missed appointments. I agree to pay any missed appointment fees charged as a result of my failing to keep a scheduled appointment without providing at least twenty-four (24) hours previous notice that I will not be able to keep the appointment.

By signing below, I acknowledge that I understand and agree to the above terms. If I am signing on behalf of another, I represent that I have full legal authority and representative capacity to execute this document on behalf of the patient.

Patient / Representative Signature

Date

Patient's Name (PLEASE PRINT)

Center for Bone and Joint Disease Representative

Date