

**HUNTSVILLE ORTHOPEDIC SURGERY AND SPORTS MEDICINE**  
**OUR FINANCIAL POLICY**

Thank you for choosing Huntsville Orthopedic Surgery and Sports Medicine as your health care provider. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor. If you have any questions or concerns about this policy please ask to speak with our financial coordinator.

PAYMENT IS DUE AT TIME OF SERVICE FOR ALL OUT OF POCKET EXPENSES.

WE ACCEPT **cash, checks, credit cards, and care credit**

**Regarding Insurance**

We may accept assignment of insurance benefits and file your claim for you. However, we do require 100% of all co-pays, deductibles and any non-covered services rendered to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, you become responsible for the balance of the account.

Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due at the time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph. It is your responsibility to verify the doctor's participation in your insurance plan.

All self-pay patients are required to pay 100% of all office visit charges at the time of service. In the event that the patient will require surgical intervention, the patient must make arrangements with the financial coordinator before being scheduled for surgery.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party

**AUTHORIZATION:**

I authorize direct payment of medical benefits to Huntsville Orthopedic Surgery and Sports Medicine. I authorize the release of medical information and records if necessary to process claims for this service. Authorization is hereby given for medical treatment for the patient listed on this form.

Signature:  patient  parent  spouse  responsible party \_\_\_\_\_ Date \_\_\_\_\_

**ACCIDENT INFORMATION**

What will we be seeing you for today? \_\_\_\_\_

Was the problem you are being seen for today the result of an accident or injury?  yes  no

Date accident occurred? \_\_\_\_\_

If yes, where did the accident/injury occur?  work  school  home  other \_\_\_\_\_

Have you been treated by any other health-care professional for this accident/injury?  yes  no

If yes, by whom? \_\_\_\_\_

Please briefly describe the accident:
