

**ORTHOPAEDIC CLINIC OF DAYTONA BEACH, P.A.**  
**1075 MASON AVENUE, DAYTONA BEACH, FLORIDA 32117**  
**(386) 255-4596**

**OUR FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to providing you the very best possible medical care and service. We regard your understanding of Our Financial Policy as an essential element of your care and treatment. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- We will verify your insurance coverage at least quarterly. It is the patient's responsibility to supply all current insurance cards.
- A \$10.00 fee will be assessed for any co-payment not made at the time of service.
- Full payment is due at the time of service for those without co-pays.
- We accept cash, checks, Visa, Discover and, MasterCard. A \$25 fee will be assessed for returned checks. Patients with two returned checks will be required to make all payments by cash, money order or credit card
- Payment plans can be arranged in advance with the Financial Accounts Representative.
- A fee equal to amount charged to Orthopaedic Clinic of Daytona Beach by a third party collection agency will be added to any account forwarded to that collection agency. Patients who have previously been in collections will be required to pay old balances in full and for all future visits at the time of service. Should any further action be required, you will be responsible for any and all administrative fees or legal fees.
- I agree to assign benefits from all applicable insurance policies (Automobile, Liability, and Health, etc.) to the Orthopaedic Clinic of Daytona Beach, P.A. for services rendered.
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. Your insurance is a contract between you and/or your employer and the insurance company. As health care providers, our relationship is with you, not your insurance company. For those plans that we participate in, we will also submit second or third insurance claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. The patient is responsible to know the rules of their health plan, as we cannot change our coding in an attempt to obtain payment. I hereby authorize the Orthopaedic Clinic of Daytona Beach, P.A. to release any medical information required in the course of examination and treatment and permit payment directly to them for any benefits or services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood and agree to the Financial Policy (above).

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

\_\_\_\_\_  
Date

**ASSIGNMENT OF BENEFITS**

I, the undersigned patient/insured, knowingly, voluntarily and intentionally assign and transfer any and all rights and benefits of my automobile insurance policy (i.e. Personal Injury Protection ("PIP"), Uninsured Motorist and Medical Payments benefits) to the above-stated Health Care Provider. I understand it is the intention of the Health Care Provider to accept this Assignment of Benefits in lieu of demanding payment at the time services are rendered. I understand that this document will allow the Health Care Provider to file suit against the insurer either in my name, or the provider's name, for payment of the insurance rights and/or benefits, to obtain an explanation of benefits and to seek attorneys' fees under Fla. Stat. §627.428 from the insurer. This Assignment of Benefits includes, but is not limited to, the cost of medical care, transportation, medication, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this Assignment of Benefits, then the insurer is instructed to notify the Health Care Provider in writing within five (5) days of receipt of this document advising of its basis for such dispute. Failure to inform the Health Care Provider shall result in a waiver by the insurer to contest the validity of this Assignment of Benefits. The undersigned patient/insured directs the insurer to pay the Health Care Provider the maximum amount of the policy benefits directly to the Health Care Provider without any reductions and without including the patient's/insured's name on the check. It is this Health Care Provider's contention that its charges are reasonable.

I, the undersigned patient/insured, certify that: I have read and agree to the above; I have not been solicited nor promised anything in exchange for receiving health care from the above-stated Health Care Provider; I have not received any promises nor guarantees from anyone as to the results that may be obtained by any treatment or service provided; and I agree that the Health Care Provider's prices for the medical services, treatment and supplies provided are reasonable, usual and customary.

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

\_\_\_\_\_  
Date

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I received the Notice of Privacy Practices for the Orthopaedic Clinic of Daytona Beach, P.A.

\_\_\_\_\_  
Name of Patient or Responsible Party (Please print)

\_\_\_\_\_  
Relationship to Patient

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

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATIONS**

I request that payment of authorized Medicare benefits be made on my behalf to the Orthopaedic Clinic of Daytona Beach, P.A. for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap/Medicare Supplement benefits be made on my behalf to the Orthopaedic Clinic of Daytona Beach, P.A. for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap/Medicare Supplement insurance carrier any information needed to determine these benefits payable for related services.

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

\_\_\_\_\_  
Date