BLUE RIDGE
ORTHOPAEDICS

AUTHORIZATION FOR RELEASE OF INFORMATION / BENEFIT ASSIGNMENT AND CONSENT TO TREAT

I authorize the release of information to my referring or family physician. I understand that you may be transferring any medical records electronically, and I absolve all parties of any liability relating to such transmission of said records. I authorize the release of medical information as necessary for treatment, and payment. I also certify that the insurance listed is correct and that all insurance benefits for services rendered are directly assigned to Blue Ridge Orthopaedics. I authorize this signature on all insurance submissions. I understand that I am responsible for any remaining balance due on my account not covered by my insurance carrier; thus if the account balance is not satisfied, the account will be transferred to the Blue Ridge Orthopaedics' billing agency, who will contact me by phone. Should this account be turned over to a collection agency for collections, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees. I consent for Blue Ridge Orthopaedics to provide care and treatment to me, or a minor child or another person for whom I have authority to sign.

Patient or Legal Guardian's Signature: _____ *Date:* _____

Acknowledgement of Receipt of Patient Financial Policy

I have read and understand Blue Ridge Orthopaedics "Patient Financial Policy" and I agree to all terms listed in the policy.

Patient or Legal Guardian's Signature: _____ *Date:* _____

Acknowledgement of Receipt of Privacy Practice

I understand that the purpose of this notice is to inform me of my rights in regards to my "Protected Health Information" and also the ways in which Blue Ridge Orthopaedics may use my Protected Health Information. I also understand that Blue Ridge Orthopaedics has my permission to use my Protected Health Information as necessary for treatment, payment and/or operation purposes.

Patient or Legal Guardian's Signature: _____ *Date:* _____

Consent for RX

I agree that Blue Ridge Orthopaedics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Patient or Legal Guardian's Signature: _____ *Date:* _____

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Financial Policy

Blue Ridge Orthopaedics has set up the following financial policies in order to provide our patients with the most efficient and cost effective service.

Self Pay: Patients without insurance are required to pay for all charges incurred at each appointment. A minimal payment of $200.00 will be expected at the first visit. Minimum $50.00 co-pay will be required at each follow-up appointment. Our office accepts cash, check, Visa/MasterCard, and CareCredit as payment. A payment arrangement may be set up through our billing department for any large balances.

Private Insurance: Patients who have not yet met their deductible are required to pay all charges incurred at each appointment. Patients who have met the deductible are required to pay their portion of the charges at each appointment. However, patients will be ultimately responsible for any remaining balance in the event we receive no response or denial from the insurance carrier.

Secondary Insurance: As a courtesy to our patients, we will file secondary insurance claims on condition that the patient provides the proper information to us. However, patients will be billed for any remaining balance after their primary insurance payment is received.

Medicare: We will file insurance claims for any patient covered under Medicare.

Managed Care: It is the patient's responsibility to know the policies for their managed care plan.

Referrals: Patients with insurance that require a referral from the primary physician must obtain this referral prior to the scheduled appointment date. The patient should either have his or her primary physician fax the referral to our office, or simply bring a copy to the appointment.

Co-pay: Patients with insurance that require a co-pay are responsible for this amount for each appointment. Patients may be required to pay their co-pay amounts at the time of check in.

Worker's Comp: We will file worker's compensation claims; however, prior approval must be obtained before the physician can see the patient.

Student Athlete: All high school student athletes are required to provide the school athletic insurance form at the time of appointment. The parent's medical insurance information must also be provided. Athletic insurance forms may be obtained from your athletic coach. The coach will fill out one portion of the form with another portion filled out by the parent(s).

Payment plans may be set up at the discretion of the billing department. Arrangements should be made prior to the appointment.