NAME(LAST)_____ **(FIRST)**_____ **(MI)**_____

DOB _____ **SS#**_____

RACE: Asian Native Hawaiian/Pacific Black or African American White Hispanic Other _____

ETHNICITY: Hispanic or Latin Non Hispanic Primary Language _____

ADDRESS _____ **APT#** _____

CITY_____ **STATE**_____ **ZIP**_____

NORTHERN ADDRESS: _____ **DO YOU HAVE A LIVING WILL? YES:**____ **NO:** _____

PHONE# (H) _____ **(Cell)**_____ **(Email)** _____

PATIENT EMPLOYER _____ **OCCUPATION**_____

PERSON FINANCIALLY RESPONSIBLE _____ **RELATION TO PATIENT** _____

PERSON'S SS#: _____ **DRIVERS LICENSE #:** _____

EMERGENCY CONTACT _____ **PHONE #** _____

FAMILY PHYSICIAN_____

ADDRESS _____ **PHONE#** _____

PRIMARY INSURANCE CARRIER _____ **CONTRACT#** _____ **GROUP #** _____

SECONDARY INSURANCE CARRIER_____ **CONTRACT #** _____ **GROUP #** _____

ATTORNEY NAME _____ **ADDRESS** _____ **PHONE #** _____

HOW ARE PAYING TODAY? CASH _____ **CHECK** _____ **CHARGE** _____

MEDICARE/MEDICAID LIFETIME AUTHORIZATION
MEDICARE AND MEDICAID PATIENTS CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII AND/OR TITLE XIX OF THE SOCIAL SECURITY ACT, IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARY CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE MEDICAID CLAIM. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY HEALTH INSURANCE DEDUCTIBLE AND COINSURANCE.

PATIENT NAME_____

SIGNATURE_____ DATE_____

FINANCIAL RESPONSIBILITY FORM
FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due upon check-in for your scheduled appointment. Payment is accepted in the form of cash, checks, Master Card, Visa, and Discover cards. Any exceptions to this arrangement must be made with a financial counselor.

Patients with insurance plans with which we participate are responsible for appropriate co-payments, deductible and other services deemed not covered by the insurance plan. We do participate with many insurance plans and networks; however, these change frequently. We suggest you check your plan's Provider Directory and consult directly with your carrier before scheduling an appointment.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. Please be aware; however, that your insurance is a contract between you, your employer and the insurance company. Not all services are a covered benefit in all contracts. It is your responsibility to be familiar with the benefits and restrictions provided by your plan.

In certain situations, such as elective surgery, you may be asked to pay a deposit based upon the procedure to be performed and the benefits verified by your insurance plan. This payment is required to be paid prior to your procedure.

Please be advised that returned checks are subject to a minimum charge of $25.00. The original amount and any additional charges must be paid in cash, credit card or cashier's checks. Failure to do so may result in your account being referred to the Attorney General's office.

Unpaid balances older than 90 days may be turned over to our collection agency and will incur an additional collection charge based on the unpaid balance. You will be responsible for all legal fees and court cost incurred as a result of this collection action.

You may not receive a bill from us while your insurance is processing your claims; however, all charges are your responsibility from the date of services rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you. Our billing department can be reach at 561-488-2200 option 4.

MEDICAL RECORDS & DISABILITY FORMS

X-rays obtained in this office are part of your permanent records and for legal purposes must remain in our office. Copies can be made at charge of $5.00 per disk. Disability forms and copies of medical records are subject to fees and are based on the number of pages.

FINANCIAL AGREEMENT AND AUTHORIZATION

I authorize the patient's insurance company, attorney or Medicare to pay direct to Golden Orthopaedic Knee and Sports Medicine Center, Inc. any medical and/or surgical expenses payable under the terms of contract.

I acknowledge that I am financially responsible to Golden Orthopaedic Knee and Sports Medicine Center, Inc. for all charges. This includes but is not limited to amounts rejected, not covered or only partially paid by my insurance plan. I agree that should this account be referred to a collection agency or attorney for collection, that I will be responsible for all collection costs, attorney's fee and court costs.

I agree to the policy of Golden Orthopaedic Knee and Sports Medicine Center, Inc. and wish to be seen. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

Name of Patient (please print: _____ MR#_____ DOB: _____

Signature: _____ Date Signed: _____