Orthopedic Institute of Michigan, PLLC
Financial and Privacy Notification

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans. (e.g. services rendered by health care providers who do not participate with my insurance plan.) All copays and office visit balances are due on the day of service. If you policy is Blue Cross Traditional or Master medical the office visit charge is due on the day of service, for Master Medical policies, as a courtesy, we will submit your claim to Blue Cross upon receipt of your payment to us. If you are an HMO patient, it is your responsibility to obtain a referral from you Primary Care Doctor; if we do not have you referral your appointment will be rescheduled. Please call 24 hours before your appointment to see if your referral is here or still valid from your last visit. It is your responsibility to know your insurance policies and coverage. Failing to do so will result in you being responsible for all costs incurred. Please remember your insurance policy is between you and your company and not with the insurance company and your doctor. If the insurance company does not make payment within 45 days, you will assume immediate responsibility for the payment and deal with the insurance directly. By signing below, you hereby authorize your insurance benefits to be paid directly to the above physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent information to the insurance carriers. I understand my right to request the presence of a chaperone during my visit. The chaperone may be a patient advocate or a staff member. Our staff will maintain patient confidentially standards set by the Orthopedic Institute of Michigan. When a chaperone is present, the provider will try to keep all questions of a sensitive nature to a minimum.

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Patient's signature

To our patients with Medicare Insurance

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic Institute of Michigan, PLLC for any services furnished me by their physicians. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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Patient's signature

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have been given the choice of receiving a copy of the Privacy Practice.
I have **Accepted** or **Refused** (Circle One) Orthopedic Institute of Michigan's Policy.

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Patient's signature

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Witness of Signatures (office use only) Date signed