SHAWS COVE ORTHOPÆDICS

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Board Certified Orthopaedic Surgeon

Dear Patient,

Since January 1st, 1995 there have been many substantial changes in insurance coverage. For instance, some patients are no longer covered by their insurance companies for visits unless **they obtain and we receive** a written referral from their primary care physician, defined as a pediatrician, internist, or family practitioner.

We will do the best we can to help you through any insurance complications. Towards this end, we are asking every patient to present his or her valid insurance card so we have accurate and up to date information on file. If you do not have your insurance card today, please send in a copy of the front and back of your card as soon as possible.

In addition, we are asking every patient, or his or her legal guardian in case of a minor, to provide a copy of your photo ID and sign the following statements which acknowledges your financial responsibility for services rendered.

Financial Responsibility of a Patient

1. I understand that I am financially responsible for all services rendered. _____ Initial

2. I understand this office participates with certain insurance companies. If my insurance is one of those, this office will bill my insurance company. I am responsible for my yearly deductible, co pays, and non-covered services. _____ Initial

3. When this office does not participate with an insurance company, as a courtesy, for expensive surgical procedures, we may agree to bill your insurance company first and await their payment before billing you for the balance due. Some insurance companies pay poorly and we are under no obligation to accept such insurance as payment in full. If you have any questions regarding your bill please direct them to the office manager. _____ Initial

4. I understand, do hereby authorize release of information to the listed insurance companies about my condition/treatment plan. I authorize direct payment of any benefits from these insurances to **Shaws Cove Orthopaedics.** _____ Initial

5. I give permission for Meridian Medical Mgmt to make informational phone calls on behalf of **Shaws Cove Orthopaedics, LLC** regarding my account. _____ Initial

6. I understand that a $75.00 "NO SHOW FEE" will be charged to me if I do not inform the office that I will not be able to keep my scheduled appointment. _____ Initial

7. I understand I will be charged a $35.00 fee if I cancel less than 24 hours prior to my appointment. _____ Initial