

### **Consent for Billing**

I request that payment of benefits be made on my behalf to Orthopedic Center of Florida (OCF), for any services furnished to me. I authorize the release of medical information to my insurance carrier if it is needed to determine benefits payable.

To our Medicare Patients: I request that payment of authorized benefits be made on my behalf to Orthopedic Center of Florida for any services furnished to me by the physician(s). I hereby authorize Orthopedic Center of Florida/any holder of medical information about me to be released to the Healthcare Financing Administration or its intermediaries/agents. I understand that I am responsible for any deductible, co-insurance, or non-covered services.

This authorization can only be revoked in writing.

### **Financial Arrangements and Medical Insurance**

Orthopedic Center of Florida is committed to providing you with the best possible care. If you have medical insurance, we will submit the claim on your behalf. It is important that you notify our office of any changes regarding your insurance coverage.

Payment for all office services is due at the time services are rendered unless payment arrangements have been approved in advance. Any charges for returned checks may be passed along to you. We accept cash, checks, Visa, MasterCard and Discover. We will file claims to your insurance carrier for reimbursement.

It is important that you understand the following:

1. Accepting Assignment does not mean we will not bill you for amounts that are deemed to be patient responsibility such as deductibles, co-insurance, co-pays and any non-covered services. If we are participating with your insurance carrier or the network your insurance carrier utilizes, we have a negotiated contract with the carrier, and agree to accept their fee schedule and they will mail the payments directly to us. The balance after our negotiated rate is your responsibility. Depending on the plan, it may be a co-insurance amount, a co-pay amount or a deductible or a combination of thereof.
2. Depending on your insurance policy, medical services may require a pre-authorization. It is your responsibility to obtain the appropriate authorization if it is required for your visit. OCF will help you in your request for an authorization from your primary care physician or PCP.
3. There may be times when your insurance carrier requests information from you as the patient that we cannot provide. It is extremely important that you provide this information to your carrier, as they may deny the claims for payment. Therefore, the balance becomes patient responsibility.

The undersigned hereby obligates him/her to pay the account for the medical services rendered. If this account is referred to a collection agency, the undersigned agrees to pay collection expenses.

By signing this form, I acknowledge that I have read and understood this form.

\_\_\_\_\_  
Signature of Patient/Guardian if patient is a minor

Date: \_\_\_\_\_