

SOBEL & ZELL ORTHOPAEDIC ASSOCIATES
OFFICE POLICY ON HEALTH INSURANCE PLANS

In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care and insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult to keep track of all the individual requirements of the plans. Each one has policies regarding how often services may be rendered and, even more importantly, where those services may be performed. Within the same insurance company there are numerous plans with differing rules, each specific to the particular contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide the care within your insurance contract guidelines if you let us know at EACH TIME OF SERVICE, exactly what those guidelines are. If referrals are required, you must provide it at time of check-in. If you do not have one with you, or it is not in the electronic system, you have the option to reschedule your visit, or pay for the visit in full at the time of service. If payment for that particular date of service is received from the insurance company, you will be reimbursed. Your signature on this page authorizes this office to make an appeal to the insurance company for payment when particular services are rendered and the insurance company has denied payment.

If your insurance plan requires a co-payment, that co-payment is due at the time services are rendered.

It is important that you know your insurance policy guidelines and restrictions.

There are certain procedures that may not be covered under your insurance coverage. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services such as x-rays, medical supplies or hospitalization that are not covered, payment for those charges is then your responsibility.

Unpaid patient balances are due within 30 days from:

- a. date of service, or
- b. date of payment from your insurance company. We will send you a statement advising you of the balance due.

Effective September 1, 2007, interest will accrue @ 1.5% monthly.

Effective January 1, 2009, a \$25.00 fee will be assessed if you fail to appear for your scheduled appointment and do not cancel at least 24 hours in advance.

Due to the increased volume of requests for assistance/completion of disability insurance forms, family medical leave act forms, and all other forms relative to patients' condition and work status, a \$5.00 fee will be assessed per form. Employer's workmens' compensation forms and state disability forms are excluded.

With your co-operation and help, we will be able to provide you with the excellent continuing medical care this community has been offered since 1985.

***** I have read and understand the office policy stated above and agree to accept responsibility as described. *****

Signature

Date

**SOBEL & ZELL ORTHOPAEDIC ASSOCIATES
CONSENT AND RELEASE**

To photograph, interview, videotape, record and publish information, statement or images.

I authorize and permit Sobel & Zell Orthopaedic Associates to photograph, videotape or record my/my child's images for educational purposes as well as advertising purposes. I understand my/my child's identity will not be revealed.

I warrant that I am of full age and have every right to contract in my own or my child's name. My signature acknowledges that I hereby waive any right to compensation for the stated uses and I acknowledge that I have read and understand the above and agree to the terms of this Consent and Release.

Print Name or Child's Name

Signature

Address

Phone

City, State, Zip

Witness

Date