

**MOORE ORTHOPEDICS & SPORTS MEDICINE, P.A.** files insurance as a courtesy to our patients. You are responsible for insurance co-payments and deductible amounts at the time of the service. Co-pays and deductibles are also required prior to surgery.

Your medical insurance is an agreement between you and your insurance company to pay a specified amount for medical care. The fees of this office are not based on the amount insurance will pay. The amount approved a particular procedure by your insurance company may be more or less than the fees charged. Full payment for your treatment remains your exclusive financial responsibility, including charges not covered by your insurance carrier.

Payment is due in (45) days after a claim has been submitted upon your behalf. If you are unable to meet your obligation, you agree to contact the business office.

This office is not prepared to wait for payments pending any legal action involving the patient and any third parties.

Those patients with no insurance are expected to make payment at the time of service unless other arrangements are made in advance.

I hereby authorize Moore Orthopedics & Sports Medicine, P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand all the physicians at Moore Orthopedics & Sports Medicine, P.A. have an ownership interest in this practice, Each share in any losses or profits of this corporation.

I understand and agree to all statements contained herein and further understand that my failure to comply with this agreement may subject me to collection activity at my expense, whether it is a collection agency or company attorney.

\_\_\_\_\_ / / \_\_\_\_\_

**Signature of patient or responsible party/relationship      Date**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Moore Orthopedics & Sports Medicine, P.A.

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**Patient signs here**

**Print patients name here**

**Date**

**MEDICARE PATIENTS ONLY**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment's of benefits apply. (This is a lifetime authorization.)

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**Signature**

**Date**