GUARANTOR:

Pts relationship to guarantor: self spouse child other employer

Guarantor name ____

Last First Middle Prefix Suffix

Guarantor DOB ___/___/_____ Social Security# ____-___-_____

Contact Information Same as patient ? Y/N If no please fill out

Street ____________________________________

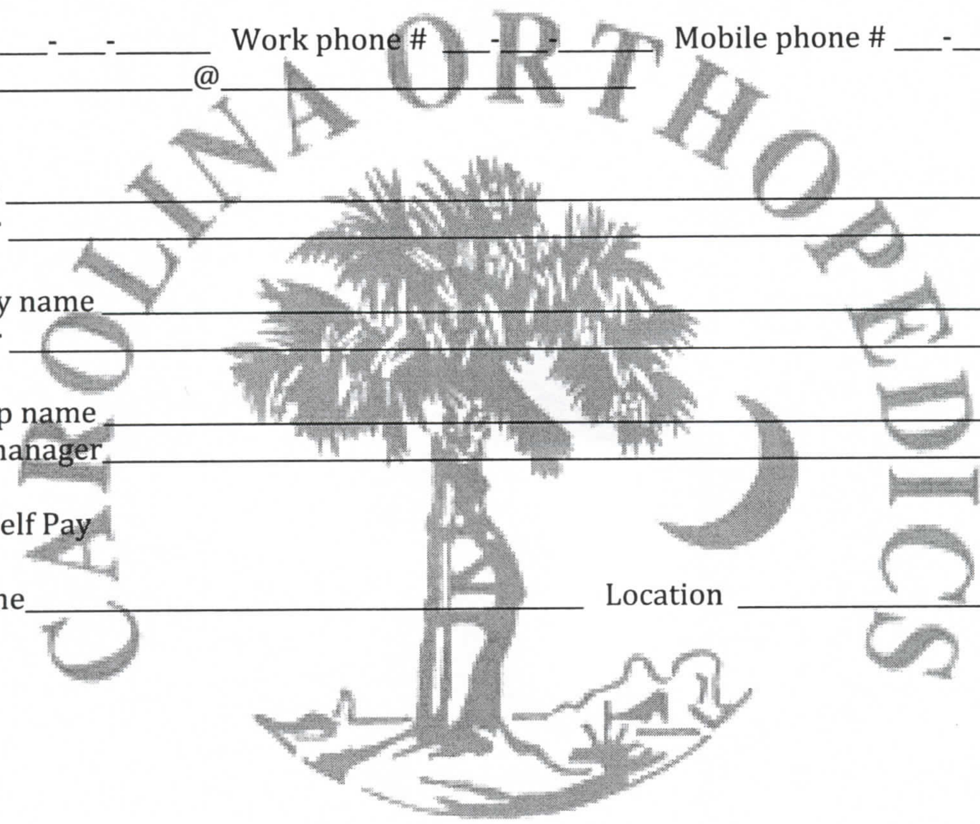
____

City ____________________ State __________

Zip __________ Country __________

Home phone # ___-___-_____ Work phone # ___-___-_____ Mobile phone # ___-___-_______

Email ____________________@____________________



Financial

Primary name ____

Number ____

Secondary name ____

Number ____

Worker Comp name ____

Case manager ____

Self Pay

Pharmacy Name__________________________ Location __________________-

PLEASE READ AND SIGN EACH SECTION

I. **Financial Policy & Payment Responsibility:** Payment for medical services is the responsibility of the patient or, in the case of a minor, the signed responsible party. Our office will file for insurance benefits for plans in which we **do participate**. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. If you are unable to pay your co-payment or co-insurance, your appointment may be rescheduled. If you insurance plan does not pay your medical services within 30 days, all charges may be due and payable in full from the patient. Your help in seeing that your insurance pays for your medical services within the specific time period is appreciated. I hereby acknowledge and accept full and final responsibility for payment of charges for medical services rendered. I understand that if payments for services rendered by this practice are not met, my account will be referred to an outside collection agency for further collection activity and a $50 collection fee will be added to your balance. If the patient no shows, or cancels their appointment more than three times, their treating physician reserves the right to discharge the patient from the practice.

Patient or Responsible Party Signature: ______________________________ **Date:** ________________

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II. **Consent for Treatment & Medical Release Authorization:** I hereby consent to treatment for myself, my child, or named minor, for who I am legally responsible. I authorize **Carolina Orthopedics** to release my medical information to any referring physician, other health care providers, hospitals and medical facilities, and to my insurance carriers for the purpose of treatment, payment and health care operation. The release of information for insurance claims, the release of past medical payment history, if requested, is authorized. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk. I furthermore, authorize **Carolina Orthopedics** to release any of my medical or financial information to the following people.

Name: ________________________ Relationship: __________________________

Name: ________________________ Relationship: __________________________

Name: ________________________ Relationship: __________________________

Patient or Responsible Party Signature: ____

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III. **Assignment of Insurance Benefits**: I hereby assign and authorize payment to **Carolina Orthopedics** of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, and third party liability coverage including personal injury protection (PIP) benefits and other medical payment coverage for which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid as an original. I hereby authorize Carolina Orthopedics to release all information necessary to secure payment of insurance benefits, **I understand that I am financially responsible for all charges whether or not paid by said insurance(s).**

Patient or Responsible Party Signature: ______________________________ **Date:** __________________

IV. **Copies of Medical Records/Images**: To obtain copies of your medical record there is an administrative charge of $15.00 plus $.65 for each page.

V. Drug Screen Policy: The physicians of Carolina Orthopedics may order a random urine drug-screening test at their discretion in the following cases: patients receiving pain medication for 90 days or more, and for patients that are referred to Carolina Orthopedics from any Pain Management Physician.

Patient or Responsible Party Signature: ______________________________ **Date:** ________________

VI. Privacy Practices: I acknowledge receipt of Carolina Orthopedics Notice of Privacy Practice.

Patient or Responsible Party Signature: ______________________________ **Date:** ______________

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VII. Telephone Messages: Messages left for your physician or his nurse will be addressed in a timely manner.

Patient or Responsible Party Signature: ______________________________ **Date:** ________________