



## Your Insurance Company

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know, or keep up with, each program's provisions.

- Some programs require that a specific facility be used for your x-rays, ultrasounds, or blood tests.
- Some programs require pre-authorization, while others do not.
- Some companies require **patients** to notify them of hospital admissions or emergency room visits.
- Some programs require specific information regarding hospitalizations.

It is **your responsibility** (to know):

- To advise this office of your program's requirements in advance, each time we provide a service.
- Out of Network: will require any deductible or co-insurance payment
- Whether this office is participating with your particular plan and program
- We will do our very best to comply with any reasonable requirements that your program may have.

Please understand this if we have not been advised in advance of your programs requirements or conditions, and we provide a service or use a laboratory that is outside of the program, you will be responsible for the appropriate fees. In addition, there are times that we may not be able to obtain a consultant or laboratory that is participating with your program. It will be up to **you** to work this out with your insurance company.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may deny all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use if you have any questions about your coverage.

· **Assignment of benefits:** I authorize payment of medical benefits directly to Orthopaedic Surgeons of L.I. for services described. I understand that I am responsible to pay for services, including insurance co-payments as well as reasonable attorney fees and costs of collection in the event of default.

· I have been provided with a copy of the Orthopaedic Surgeons of L.I.'s **HIPPA Privacy Notice** and have been given an opportunity to read and ask questions about the notice.

· **Lastly, I authorize the following individual(s):** \_\_\_\_\_

**to receive any medical information on my behalf.** \_\_\_\_\_

*Patient Signature*

•**For patients insured by Medicare:** I authorize any holder of medical or any other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*