WESTERN PA ORTHOPEDICS & SPORTS MEDICINE, INC.
2 Celeste Drive, Johnstown, PA 15905 814-255-6781

REFERRAL AND PAYMENT RESPONSIBILITY

I, the Guarantor, understand that I am fully responsible for all fees payable to Western PA Orthopedic & Sports Medicine, Inc., 2 Celeste Drive, Johnstown, PA 15905, for any medical care and diagnostic imaging studies (x-rays) rendered by the physicians and staff of Western PA Orthopedic & Sports Medicine, Inc.

REFERRALS: If my insurance company requires a referral, I understand that it is my responsibility to obtain a referral before my scheduled appointment and to bring that referral with me to the appointment. **If I do not have a valid referral at the time of my appointment, I acknowledge that I am personally responsible for any services that are not covered by my insurance or I may have to reschedule my appointment.**

WORKERS' COMPENSATION, MOTOR VEHICLE AND LEGAL CASES: I understand that if I am involved in any of these type of injuries or cases that I must present all relevant documentation to Western PA Orthopedic& Sports Medicine, Inc., before my appointment. I acknowledge that I have reported any and all injuries to my employer, insurance agent, insurance carrier and discussed all this information with a member of the Billing Department of Western PA Orthopedic & Sports Medicine, Inc. I must also present my personal health insurance card, in the event that services are denied under my case. If all the appropriate information is not presented prior to my appointment, I understand and agree that all unpaid balances become my responsibility.

CLAIM SUBMISSION: Depending on my insurance plan, the physician's office may file a claim for services directly to the insurance company. I am aware that the physician I am to see may participate or may not participate with my health insurance plan(s). **I agree to contact the customer service department of my insurance company if I am unsure of their requirements or my benefits and to determine if the physicians are in my insurance company's provider network.**

NON-COVERED SERVICES: I understand that this office may provide me with special services or orthopedic equipment that may not be covered by my insurance company. In the event that I may require any of these special services, I am aware that I am fully responsible for payment if I choose to receive any special services or orthopedic equipment.

CO-PAYS, DEDUCTIBLES AND CO-INSURANCE: I understand it is my responsibility to know the requirements of my health insurance plan(s). By signing the agreement, I acknowledge that I am fully aware of my co-pays, deductibles and co-insurance. I acknowledge that the physicians' office will bill me for balances due and that I am fully responsible for all balances billed to me. **I am also aware that my co-pay must be paid at the time of my visit.**

PAYMENT PLANS AND COLLECTIONS: In the event that I do not have insurance, I understand and agree that payment is required the day of my visit. If I am unable to pay my entire balance, I may arrange to make reasonable monthly payments. If I am not consistent with my monthly payments, after attempting one notice, the credit bureau may be notified and my unpaid balance may be placed with a collection agency. **I understand and acknowledge that the physicians' office can submit my unpaid balance due over 90 days old to a collection agency and notify the credit bureau.**

CLAIM AUTHORIZATION: I request that payment of authorized Medicare payments may be made on my behalf to the physician or group indicated on the claim for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish the above-named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE:
I hereby authorize release of information necessary to file a claim with my insurance company and **assign benefits otherwise payable to me, to the doctor or group indicated on the claim.**

I have read and fully understand all of the above statements. I agree to comply with all stated requirements.

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Patient/Guarantor's Signature Date