Hampton Roads Orthopaedics & Sports Medicine
Payment Policy

THIS SECTION MUST BE COMPLETED BY ALL PATIENTS

PAYMENT POLICY AND INSURANCE ASSIGNMENT/RELEASE: The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and Hampton Roads Orthopaedics & Sports Medicine. I authorize the filing of claims (electronically and/or hard copy) against any insurance in force and other third party payor including: Medicare, Medicaid, or Workers' Compensation carriers, and further assign direct payments to Hampton Roads Orthopaedics & Sports Medicine. The undersigned understands that he/she is responsible for payment of any charge not covered by this agreement, and that any monies recovered in excess of the patient's indebtedness will be refunded. In the event of any default on any payment due Hampton Roads Orthopaedics & Sports Medicine, I agree to pay all costs including 33 1/3% collections and attorney fees. I authorize the release of any medical information to process claims for services rendered. I understand there is no guarantee of treatment outcomes.

I have been made aware that the surgeons of Hampton Roads Orthopaedics & Sports Medicine have ownership in Hampton Roads Orthopaedics & Sports Medicine Physical Therapy, Hampton Roads Orthopaedics & Sports Medicine Interventional Pain Management, the Open Multi-Positional MRI Center, and the Mary Immaculate Ambulatory Surgery Center.

I have read, understand, and agree to the Payment Policies described above.

_____ _____

Patient/Parent/Guardian Signature *Print Patient/Parent/Guardian Name*

_____

Date

THIS SECTION MUST BE COMPLETED BY ALL PATIENTS

If I do not have active insurance or a valid referral (if applicable) today, I understand that I will have to pay for today's visit. I understand that if my insurance company requires a referral, I have to inform HROSM. I also have to get a referral for this date of service. **By signing this form, I agree that I will be paying for today's visit if my insurance company does not pay. The estimated cost of services for todays' visit is $363.00. I understand that this payment is non-refundable.**

INITIAL: _____ **DATE SIGNED:** _____ **TIME SIGNED:** _____

Complete this section if you have MEDICARE, MEDICAID, or TRICARE:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare/Medicaid/Tricare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

INITIAL: _____ **DATE SIGNED:** _____

Appointment Cancellation and No-Show Policy

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so will result in a missed appointment fee of $50.00 **By initialing below, you acknowledge your understanding of this policy.**

INITIAL: _____ **DATE SIGNED:** _____