

**NORTH VALLEY ORTHOPEDIC & HAND SURGERY
A MEDICAL CORPORATION**

PATIENT NAME _____ **DATE OF BIRTH** _____

As a courtesy to you, NORTH VALLEY ORTHOPAEDIC AND HAND SURGERY will bill your insurance. However, please remember that insurance is considered a method of reimbursement to the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **IT IS YOUR RESPONSIBILITY TO PAY ANY BALANCE NOT PAID BY YOUR INSURANCE WITHIN 90 DAYS AND ANY SERVICES NOT COVERED SPECIFICALLY BY YOUR INSURANCE.**

Please check with our business office at the time of your visit to confirm and arrange for payment of services rendered, whether by insurance coverage or payment arrangements. We do accept Visa, MasterCard, and American Express for payment of services.

We reserve the right to charge interest at 10% per month on balances outstanding more than 30 days.

If your account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient record. A copy of the "Privacy Notice" has been made available to me outlining the allowed uses of my medical information. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, other health plans, and any third party liability payments as may be applicable to:

NORTH VALLEY ORTHOPAEDIC AND HAND SURGERY

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to the appropriate insuring parties to secure payment for services.

SIGNED _____ **DATE** _____

RESPONSIBLE PARTY _____ **DATE** _____

Neither my spouse nor I have medical insurance coverage, and we agree to be responsible for any fees incurred for any medical treatment the above noted patient received or may receive. If retroactive medical coverage is obtained, we **AUTHORIZE PAYMENT TO THE PHYSICIAN.**

SIGNED _____ **DATE** _____

RESPONSIBLE PARTY _____ **DATE** _____