ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

FINANCIAL POLICY ACKNOWLEDGEMENT

ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C. herein referred to as ("ESMOS") is committed to the success of your medical treatment and care. We understand with the constant changes to insurance carriers' plans, the patients financial responsibility can create confusion. Because of this, we have outlined in detail our practice's policy. If you have any questions our billing staff would be happy to assist you.

COMMERCIAL INSURANCE

Insurance contracts and policies are between you, the patient, and your insurance company. **Any services not paid by your insurance company are your responsibility.** Contact your insurance carrier or plan administrator if you have any questions regarding co-payments, referral requirements and benefits. Once we receive payments from your insurance company, any outstanding balance is your responsibility.

ALL PAST DUE BALANCES ARE DUE AT TIME OF SERVICE

Payment plans can be arranged by contacting our Business Office. If your account is not paid in a timely manner, the full balance may be placed with an outside collection agency or attorney for further collection efforts. In the event your account is sent to collections an additional 33.3% will be added to your outstanding balance as collection fees and/or attorney fees. This balance will be reported on your credit report and remain there for seven (7) years. A returned check fee will be added to your balance. There is a 4% fee on all credit card usage.

WORKER'S COMPENSATION/INDUSTRIAL INJURIES

If our office is not informed of a related Worker's Compensation claim at the initial visit, you will be liable for all charges. Also, we will request any other (private medical) insurance coverage information you may have at this time. If a Worker's Compensation claim is still in process or services are denied by the Department of Labor, NSMDPC will bill the private insurance company provided. The patient is then responsible for any remaining balance.

SCHOOL/LEAGUE/REC

All injuries due to school, league or rec will be billed to the primary insurance carrier. Balances are then forwarded to S/L/R insurance. In order for claims to be paid an injury form and accident report must be completed and provided to this office within 60 days.

CHILD CUSTODY CASES

The parent accompanying a child to a first appointment assumes full responsibility for the patient account. Our office does not get involved with divorce specifics. It is the parents' obligation to work out any agreement with one another or through the court system.

PATIENTS WHO ARE MINORS

A parent or legal guardian must accompany patients who are minors on the patient's first visit. In the event they are unable to be present, the accompanying adult is authorized to sign on my behalf and I further agree to take responsibility for payment of the account according to the financial policy.

NO INSURANCE/SELF-PAY PATIENTS/LITIGATION

Payment in full is due at the time of service. For self-pay patients, a payment plan can be arranged by contacting our business office. In case of a litigation claim, such as a work related injury being contested by an employer or automobile accident, a letter of protection from your attorney is required.

COMMERCIAL, WORKERS COMPENSATION, NO-FAULT AND OTHER INSURANCE

I verify the accuracy of the information on this form. I hereby authorize direct payment of surgical/medical benefits to my physician, for services rendered by him/her in person or under his/her supervision if I have not paid in advanced. In the event my insurance carrier submits payment directly to the policy subscriber, I agree to endorse all checks and remit to ESMOS. I understand that such payments legally belong to ESMOS. I understand that I am financially responsible for all services. Additionally, I will work with the doctor's office to have Worker's Compensation and No-Fault claims paid to the doctor, and I understand that all bills are my responsibility if not paid by the carrier. I hereby authorize my physician, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I have read and agree to the above financial policy.

By signing this policy you consent to be contacted on the cellular phone provided via call or text, and also by email.

PATIENT'S NAME

PATIENT'S PARENT/GUARDIAN SIGNATURE

DATE