Upper Hand ORTHOPAEDICS

ACKNOWLEDGEMENT AND CONSENT

I understand that Upper Hand Orthopaedics will use and disclose health information about me.

I understand that my health information may include information both created received by Upper Hand Orthopaedics , may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Upper Hand Orthopaedics may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment; and/or
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment and/or
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care, and/or
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality cost-effective health care.

I also understand that I have the right to receive and review a written description of how Upper Hand Orthopaedics will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Upper Hand Orthopaedics, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Upper Hand Orthopedics' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Upper Hand Orthopaedics is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

By: _____ Date: _____
(Patient's Representative)
Description of Representative's Authority: _____

Official Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communication barrier prohibited obtaining the acknowledgment
□ Emergency situation prevented us from obtaining acknowledgment
□ Other (Please Specify) _____

Staff: _____ Date: _____

Upper Hand ORTHOPAEDICS

Financial Policy

Upper Hand Orthopaedics has a financial policy in place that clearly identifies patient and practice financial obligations. We are committed to providing our patients with the best medical care possible and this financial policy has been created in order to allow us to do so while avoiding any misunderstanding or disagreement concerning payment for professional services.

If you are covered by a contracted insurance plan you are required to pay any co-pay at the time of your visit. Any collectible co-insurance balance remaining after insurance payment will be due in full upon receipt of our monthly statement.

If you are covered by a non-contracted insurance plan, you are expected to pay any co-pay at the time of your visit. Our office will file an insurance claim for our services. However, non-contracted insurance companies may not pay fully for your services. Any balance remaining after insurance payment or non-payment will be due upon receipt of our monthly statement.

For patients without insurance, we offer a 10% self pay adjustment. At minimum, a $125 deposit is required at first visit, and $50 deposit and each subsequent visit. Patients requiring surgery will need to pay 50% of the estimated surgeon costs prior to the surgery. Payment plans will be arranged for the balance.

Payment for professional services can be made with cash, check or credit card.

If your insurance requires referrals please make efforts to obtain the referral prior to arrival, you may also call our office for guidance.

Our staff is available to help with insurance questions relating to how a claim was file or regarding any additional information the carrier might need to process the claim. Specific coverage issues are addressed by the insurance company member services department available at the phone number listed on the back of your insurance card.

Accounts that become delinquent may be subject to collection activity.

A service charge of $25.00 will be assessed for checks returned for insufficient funds or checks written on a closed account.

I have read and accept the credit policy terms outlined above. I agree that in the event additional costs and/or fees are incurred in connectional with the collection of my account, I will pay all such costs and fees, including collection costs, attorney fees and all court costs.

In addition, I authorize Upper Hand Orthopaedics to provide my insurance company(s) all information necessary to process insurance claims and assign to Upper Hand Orthopaedics, PC, all of the insurance benefits due to me to the full extent of my financial obligations. A photocopy of this authorization shall be considered as valid as original.

_____ _____

Signature of Patient or Responsible Party Date