OSBORNE ORTHOPEDIC GROUP, INC.

PATIENT INFORMATION (please print)

NAME:(Last)_____(First)_____(Middle)_____

ADDRESS:(Street/P.O.Box)_____

(City)_____(State)_____(Zip)_____

EMAIL: _____

DATE OF BIRTH: _____ **AGE:** _____ **SS#:** _____-_____-_____

PHONE NUMBER(S):(Home)_____(Cell)_____(Work)_____

PCP (WITH PHONE NUMBER): _____**REFERRED BY:** _____

(CIRCLE ONE) sin mar div wid **PREFERRED LANGUAGES:** _____

RACE (LIST ALL): _____ **GENDER: M F**

EMPLOYER NAME AND PHONE: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT PERSON: _____

(Name) (Relationship to you) (phone)

BILLING INFO (Person Responsible for Paying the Bill)

NAME: _____**RELATIONSHIP TO PATIENT**_____

SS# _____-_____-_____ **BIRTHDATE:** _____

PRIMARY INSURANCE: _____**POLICY #**_____

POLICY HOLDER NAME: _____**GROUP #** _____

SECONDARY INSURANCE: _____**POLICY #**_____

POLICY HOLDER NAME: _____**GROUP #** _____

I consent to treatment by the physicians and/or associates of Osborne Orthopedic Group, Inc. I assign my insurance disbursement to be paid directly to Osborne Orthopedic Group, Inc. I understand that billing my insurance company does not guarantee payment from the insurance company to Osborne Orthopedic Group, Inc, and that I am financially responsible for payment of all charges.

SIGNATURE: _____**DATE**_____

PRINTED NAME: _____

OSBORNE ORTHOPEDIC GROUP, INC CREDIT AND FINANCIAL POLICY

Thank you for choosing Osborne Orthopedic Group, Inc. as your healthcare provider. We are committed to the success of your treatment. Please understand that prompt payment of your charges is considered part of that treatment. Details of our CREDIT AND FINANCIAL POLICIES are listed.

Please read carefully and sign below.

1. All patients complete our registration and insurance forms.
2. FULL PAYMENT IS DUE AT THE TIME OF SERVICE
3. For your convenience, we accept cash, checks, MasterCard and VISA.
4. We offer payment plans with prior approval and a signed agreement.
5. In the event the payment agreement is not honored, the entire balance on the account will be due.
6. If your services/accounts are in litigation, please note that Osborne Orthopedic Group, Inc. **does not provide services on a contingency basis**. Payment is expected at the time services are rendered, unless other arrangements have been made.
7. A service charge of $40.00 will be added to your account for all returned checks. If more than 2 (two) checks are returned, we will only accept cash or credit card payment for any outstanding charges and for any future services rendered.
8. A $25 fee will be assessed to your account for a no-show with failure to cancel/reschedule an appointment with 24 hours notice. (757-548-7190)
9. A $100 fee will be assessed to your account for a no-show with failure to cancel/reschedule surgery with 48-hour notice. (757-548-7190)

PATIENTS WITH INSURANCE COVERAGE

1. We accept assignments of insurance benefits. However, we do require your co-payment, coinsurance, and deductibles to be paid at the time of service.
2. The balance incurred is your personal responsibility whether your insurance carrier pays or not.
3. Coverage amounts vary from insurance policy to policy, and we cannot guarantee the amounts of coverage offered by your insurance carrier.
4. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy.
5. You understand that your insurance policy is a contract between you and your insurance carrier. Osborne Orthopedic Group, Inc. holds no party to that contract and will not be held responsible in the event your insurance company denies any claims.

DELIQUENCY

In the event your account becomes past due and is sent to collections, you will be responsible for the collection costs along with attorney fees, interest, and court costs incurred by Osborne Orthopedic Group, Inc.

I have read and understand the Osborne Orthopedic Group, Inc. CREDIT AND FINANCIAL POLICY with respect to payment on my account.

_____ _____

Signature of Patient of Responsible Party Date

Printed Name: _____