I understand that Sonoran Orthopaedic Trauma Surgeons PLLC and their respective designees will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

• **ASSIGNMENT OF INSURANCE AND APPOINTMENT OF LEGAL REPRESENTATIVE:** I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider

• **AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

• **FINANCIAL LIABILITY:** I have been provided a copy of the SOTS financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to SOTS for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

• My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at SOTS and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
• My health plan determines that the services I receive at SOTS are not medically necessary and/or not covered by my Insurance plan, and/or
• My health plan coverage has lapsed or expired at the time I receive services at SOTS, and/or
• I have chosen not to use my health plan coverage.

• **POLICY FOR THE COLLECTION OF PATIENT DEDUCTIBLES, COINSURANCE AND OTHER PATIENT BALANCES:** The Practice will ***never*** waive any coinsurance, deductible or other patient responsibility except for reasons of financial hardship as set forth in the attached Charity Care Policy. The Practice will ***never*** waive a balanced bill, that is, the different between charge and payment for out of network patients of the Practice (hereinafter, "Balance Bill"), except for reasons of financial hardship as set forth in the attached Charity Care Policy. The Practice shall immediately bill patients for any coinsurance, deductible or other patient responsibility upon receipt of an EOB or other correspondence from the payor that such coinsurance, deductible or other patient responsibility is payable by the patient. The Practice shall bill patients for a Balanced Bill after but not before the first level appeal for increased reimbursement is filed by the Practice. In some cases, the Practice shall bill patients for a Balanced Bill after a second level appeal is filed by the Practice. Patients of the Practice shall sign for receipt of the Practice's Charity Care Plan, an Assignment of Benefits and Consent Form at the time services is first rendered by the Practice. The Practice understands that both State and Federal law require that the patient be provided a Balanced Bill Statement. The Practice will ensure that patients understand that they are responsible for deductibles, coinsurance, the balanced bill and any other patient responsibility designated by the payer's EOB. Patients must return claim checks sent to patients within 10 days of receipt to avoid collections.

• **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to SOTS. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

ASSISTANT AT SURGERY: I understand I may receive certain ancillary medical services from SOTS. I understand that physician assistants may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payer.

LIENS: I fully understand that I am directly responsible to said doctors for all medical bills submitted by SOTS for service rendered me and that this agreement is made solely for said doctors' additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. Further, I hereby authorize and direct my attorney to pay directly to SOTS such sums as may be due and owing for medical service rendered me and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect SOTS.

FRACTURE/SURGICAL CARE: Fracture/Surgical Care is billed out as a "packaged" service which includes the following: Evaluation, the first cast, splint, boot application, and/or surgery and 90 days of postoperative follow-up care from the date of the fracture. ***There are some service that we bill separately*** which include: any casting supplies, replacement cast applications, evaluations for any ***additional*** problems or injuries and treatment of complications. Your insurance carrier requires that we report our services using the coding system known as the *Current Procedural Terminology* (CPT). The codes for fracture care can be found in the *Surgery* section of the CPT book. This is not to imply that you will have or had surgery or that you will be or were taken to the operating room. This is how the CPT book was set up by the *American Medical Association* (AMA) for user-friendly purposes by both the insurance companies and physicians. ***Please note, your insurance company may cover these services for fracture/surgical care differently than office visits. Therefore, your services may be paid as a surgical procedure, with deductible and co-insurance guidelines applied.***

SURGICAL CARE IN AN OUTSIDE FACILITY (hospital or SurgCenter): If you have surgery in an outside facility you will receive a bill from us representing the surgeons' fee. In addition, you likely will receive a separate bills for services rendered by the hospital or surgcenter, anesthesiology and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

If you have any questions or concerns, please contact our Billing Department at 480-874-2040

• **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided SOTS Patient Financial Polices. I understand the information listed above which has been fully explained to me.

____ **Date** _________________

Patient Signature

____ **Date** _______________

Guarantor Signature