Spine and Orthopedics of Atlanta, LLC
Statement of Patient Financial Responsibility, Payment of Benefits

Patient Name: _____ DOB: _____

Spine and Orthopedics of Atlanta, LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amounts not covered by your insurer.** If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.
I hereby assign and authorize payment to Spine and Orthopedics of Atlanta, LLC, of all medical and surgical benefits, to which I am entitled to under any insurance policies/programs or other benefit programs.
I request payment of Medicare benefits to Spine and Orthopedics of Atlanta, LLC for services rendered. I understand that I will be notified by Spine and Orthopedics of Atlanta , LLC, if Medicare or other insurance is likely to deny or denies payment for services and I will be responsible for payment. I understand that the above assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept responsibility, including, but not limited to, payment of the fees and charges not directly reimbursed to Spine and Orthopedics of Atlanta, LLC, by any insurance policy, plan, or benefit program.

I authorize Spine and Orthopedics of Atlanta, LLC physicians and staff to administer medical treatment.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

By signing below, I authorize Spine and Orthopedics of Atlanta, LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate medical assessment and treatment procedures.
I further authorize Spine and Orthopedics of Atlanta, LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment. This includes information related to pyschiatric care, drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims or any medical information that is required for any health care related utilization review and/or quality assurance activities and/or attorneys, upon authorized HIPAA compliant request form.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Spine and Orthopedics of Atlanta, LLC, will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.
I understand I have a right to receive a copy of this authorization. This authorization shall remain in effect until revoked in writing; a photocopy of this authorization is considered as valid as the original.

Patient/Guarantor Signature _____ Date _____

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