NJ Ortho Group, LLC

DO YOU HAVE AUTHORIZATION TO BE SEEN IN OUR OFFICE? IF NO, PLEASE BE ADVISED THAT IF YOUR INSURANCE COMPANY MAY NOT PAY and YOU WILL BE RESPONSIBLE FOR YOUR BILL.

It is our office policy that all services rendered are charged directly to the patient, and that you are ultimately and personally responsible for payment of all services rendered, regardless of any personal insurance you may have.

1. **Patients with no insurance**: Payment is expected at the time of service. A specific payment plan acceptable between you and billing office may be arranged.
2. **Patients with insurance**: Deductibles and all co-payments are expected at the time of service. Your co-payment is an amount, which is not covered by your insurance and is not always and exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility.
3. If a patients account balance remains unpaid for more than 90 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expenses. Please also note the following:

1. The privilege of insurance assignments begins when your insurance is qualified and forms are received. Until that time you must pay for services rendered.
2. All deductibles must be made prior to submitting any insurance claims.
3. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.
4. This office does not promise that an insurance company will pay the usual and customary charges of this office, nor does this office enter into any dispute with an insurance company concerning the amount of the reimbursement.
5. Lastly, it is the goal of this office to provide you with the finest quality care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

OUT OF NETWORK

I have been made fully aware that NJ Ortho Group, LLC and their providers **DO NOT** participate with my insurance. I **AGREE** that **I will be held Responsible** for **ANY** and **ALL Remaining Balances that my Insurance company WILL NOT PAY**.

_____, ____/____/_____ _____ ____/____/_____
Signature of responsible party Date Signature of patient Date

I have reviewed and am aware of the payment policies of NJ Ortho Group, LLC.

_____, ____/____/_____ _____ ____/____/_____
Signature of responsible party Date Signature of patient Date

I authorize my insurance company to make payment for my unpaid balance directly to the NJ Ortho Group, LLC.

_____, ____/____/_____ _____ ____/____/_____
Signature of responsible party Date Signature of patient Date

I hereby authorize the release of any information relating to my care directly to my insurance company, attorney, school or any other treating specialists.

_____, ____/____/_____ _____ ____/____/_____
Signature of responsible party Date Signature of patient Date

MEDICATION POLICY

MEDICATION PRESCRIPTIONS OR REFILLS WILL NOT BE CALLED IN AFTER HOURS ON WEEKNIGHTS, FRIDAYS, WEEKENDS OR HOLDIAYS UNDER ANY CIRCUMSTANCES. IT IS YOUR RESPONSIBILITY TO MONIOTR THE AMOUNT OF MEDICATION YOU HAVE. THEREFORE, YOU CANNOT EXPECT THE PHYSICIANS

TO CALL IN REFILLS ON THE SAME DAY OF YOUR REQUEST. YOU MUST ALLOW THE DOCTORS AT LEAST 2 DAYS TO CALL IN YOUR REFILL OF YOUR CURRENT MEDICATION.

_____, ____/____/_____

Signature of patient/responsible party Date