SOS Financial Consent

Patient's Name: _________________________________ DOB: ______________________

Email: ______________________________________ Acct #: ______________________

Thank you for choosing SOS to be your Orthopedic Provider. As a patient you have certain responsibilities in regards to your insurance contract:

1.) To pay amounts not covered by your policy including applicable copays, co-insurance and deductibles.
2.) To be knowledgeable about your plan's covered and non-covered services.
3.) To provide your provider's offices with accurate and up to date insurance coverage.

By signing this patient financial agreement, you agree to be billed as a self-pay patient should you fail to supply valid, accurate insurance information at the time of service.

Due to strict timely filing rules and government regulations, you also agree to notify us right away- no later than 30 days after you receive notification that you are eligible for additional coverage(s) including Medicaid, Medicare, Medicare Advantage plans or other supplemental policies. Should you fail to give us timely notification of additional coverage (including Medicaid or Medicare eligibility), you will be considered a self-pay patient and agree to be held personally responsible for payment of your charges.

If you are being seen for a workers compensation injury and an agreement is executed by you and approved pursuant to workers compensation law 32 in which you waive your right to medical benefits from the worker's compensation carrier for treatment services performed after the date the agreement is approved, the provider may bill you directly instead of the employer or insurance carrier and you will be responsible for the provider's fees for services rendered.

You may be advised of your estimated patient responsibility for services rendered. Additionally, you agree that any claim service denied by our carrier is your personal responsibility to pay until such time that we receive reimbursement from your insurance carrier(s). Thank you.

Printed Name: _________________________________ DOB: _____________________

Signature: _____________________________________ Date: _____________________

Relationship to Patient: _________________________________

updated 2.11.19