ARVADA SPORT and SPINE GROUP

12189 W. 64th Ave. Suite 102 Arvada, CO 80004 303-424-9549 www.arvadasportandspine.com

Authorization, Assignment, Privacy and Your Health Information

To: Arvada Sport and Spine Group. In consideration of your understanding to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

I authorize Arvada Sport and Spine Group to release any information it deems appropriate concerning my physical condition to any insurance company, attorney, collection agency, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered, and I hereby release Arvada Sport and Spine Group of any consequences thereof.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize and direct the payment to you for all services of any sum I now or hereafter owe you, by my attorney directly out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for your services. This is a direct authorization to the attorney to pay such sums from funds that he/she may receive into his/her trust account in connection with my personal injury or workman's compensation case.

ACKNOWLEDGEMENT AND UNDERSTANDING

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. I agree that Arvada Sport and Spine Group is not obligated to wait for any payment for services rendered more than 30 days after the date of each billing.

I understand that if it is determined either:

a) That there is no insurance company obligated to pay for all or part of the services, or if the insurance company involved refuses to pay all or part of the invoices; or

b) If a liability claim for medical payments or reimbursement exists, and my attorney is unable to obtain payments from the insurance company for all or part of the bills within a reasonable time, not to exceed 30 days after the date of billing, or if I have not engaged the services of any attorney; then, full payment for services rendered by the staff and/or doctors at Arvada Sport and Spine Group will be made by me on a current basis, and my bills shall be paid in full by me whether or not my liability claim is then or about to be settled. In the event I default, I agree to pay, whether or not legal proceedings are instituted a reasonable collection fee for any debt incurred hereunder and to pay all reasonable attorney fees as a result of my default. I also agree to pay a reasonable returned check fee on any returned checks written to Arvada Sport and Spine Group.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the privacy practice notice for Arvada Sport and Spine Group. I understand that Arvada Sport and Spine Group will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy notice. Arvada Sport and Spine Group will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Arvada Sport and Spine Group has prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that Arvada Sport and Spine Group will file my insurance as a courtesy. However, I clearly understand and agree I am ultimately responsible for all service fees related to my care should my insurance deny for reasons such as: an authorization, deductible, no coverage, non-covered services or any other reasons. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I accept full responsibility for payment of all charges and authorize the treatment provided to the patient.

I understand that if I cancel a scheduled appointment within 24 hours / 1 business day of the set appointment time I will be subject to a $40 fee (per provider) that will not be billed to any insurance company and will be due immediately.

I have read, completely understand, and agree to ALL of the above statements. I understand that my signature below pertains to each statement above. I further understand that I may refuse to sign this document.

You have my permission to discuss anything relevant to my care at Arvada Sport and Spine Group including, but not limited to, my condition, my treatment, my account finances, and my appointments with the persons listed under "Authorizations" below:

Authorizations:_____

Print Patient Name: _____ _____

Patient/Parent Signature: _____ Date: _____