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

You are authorized to release any information you deem 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 by you, and I hereby release you of any consequences thereof.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

In consideration of all services rendered and to be rendered to me, 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. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
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. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.
I hereby acknowledge that I am receiving (or about to receive) health care services at Arvada Sport and Spine Group. Arvada Sport and Spine Group is not obligated to wait for any payment for such services more than 30 days after the date of each billing, and I am obligated to pay the full bill, with or without insurance reimbursement for all or part of such bill, within 30 days after billing or further services do not need to be provided me.

I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges for services provide to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a minimum monthly billing charge of $5.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to current standard of care in this area. When your schedule of visits is once per month or longer, you understand that most insurance companies consider this to be maintenance care and you may not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered.

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 authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

As we seek to respect your time we ask that you do the same for us. If you cancel or miss a scheduled appointment within 24 hours of the set appointment time you may be subject to a $45 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: _____