DANVILLE ORTHOPEDIC CLINIC
FINANCIAL POLICY

If you are covered by an insurance carrier we will file a claim for you at no cost. Any balance remaining after insurance payment will be due immediately.

You are responsible for all charges regardless of any pending insurance. If your insurance plan does not pay because it is an HMO plan (a plan where you must see a physician in your network), whether commercial insurance or Medicare, you will be held responsible. We accept payment by cash, personal check, VISA or MasterCard. Payment is due at the time of service.

There is a $10.00 charge for disability forms related to loan repayments, payable in advance.

We do accept Virginia and NC workman's compensation, but the patient is required to provide us with the billing information. WE DO NOT ACCEPT OTHER STATE'S WORKMAN'S COMPENSATION.

All account balances are considered past due after 60 days.

In the event that your account shall have to be placed with an attorney or collection agency, you will be responsible for an attorney or collection fee of 25% of the balance due.

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS:

I, the undersigned, request and authorize the payment of Medicare and/or other insurance in whole or in part, services rendered to me, or one or more of my dependent(s), by the DANVILLE ORTHOPEDIC CLINIC, INC. (the "CLINIC") be made direction to the CLINIC, notwithstanding Section 38.2-2201 (B) of the **Code of Virginia**, 1950, as amended. If my treatment or the treatment of my dependent(s) relates to an injury for which I am entitled to recover for my personal injury from a third party, I hereby assign to the CLINIC such portion of my recovery sufficient to cover all charges for services rendered to me with respect to such injuries by CLINIC. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and/or other insurance companies, and its agents, any information needed to determine these benefits or the benefits payable for related services.

I will allow Danville Orthopedic Clinic to release to any health care facility any medical records deemed necessary for my continued care. I will also allow them to obtain any medical records from my previous healthcare providers necessary for my current treatment.

SUBROGATION NOTIFICATION

Your plan may contain a Subrogation clause. It is necessary that we advise you that as a Participant in the plan (or your dependent), you must reimburse the plan for benefits paid by the plan from any monies you (or your dependent) receive, in whole or in part, from a judgment or settlement, made by a third party from any recovery. You as the participant or the dependent must also take action to assist the plan in recovering this reimbursement. You (or your dependent) must sign and deliver all necessary documents that the plan may need to enforce its rights to obtain reimbursements.

By signing below I indicate that I have read this financial policy and agree to its terms and authorizations.

Signed____Date____________________

Responsible Party (if under 18)____Date____________________