Assignment of Benefits/Consent for Treatment
FINANCIAL POLICY

Thank you for choosing OSMC as your health care provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our **Financial Policy** which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check or VISA, MasterCard, and Discover credit cards.

REGARDING INSURANCE:
We participate in many insurance plans and networks. It is the patient's responsibility to determine if the provider they are seeking services with participates in their health insurance plan or network. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance plans.

RETURNED CHECKS:
For checks returned to us as unpaid by your bank, we will charge a $30.00 fee.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors we will provide only emergency care unless other arrangements have been made prior to the service.

Medicare Once in a Lifetime Authorization (If applicable)
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic & Sports Medicine Center of Northern Indiana, Inc. (OSMC) for any services furnished to me by the physician and providers of OSMC. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine payments for related services.

Assignment of InsuranceBenefits/ Consent
I authorize release of medical information to my insurance carriers for services rendered by the providers of OSMC and all affiliated corporations. In addition, I also authorize the release of payment information from my insurance carriers to OSMC and all affiliated corporations. In addition, I request payment(s) of authorized benefits be made directly to OSMC and all affiliated corporations. I understand I am responsible to pay all non-covered services.

My health care provider may determine it is necessary to perform diagnostic tests, medical, and /or surgical procedures judged by him/her as necessary for my treatment and advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my provider as to the result of any treatments, examinations, and/or operative procedures performed in the office.
I authorize treatment by the attending provider.

I have read the Financial Policy. I understand and agree to the Financial Policy.

____ ______________________

Signature of patient, Legal Guardian or Legal Representative Date

2310 California Road
Elkhart, IN 46514
574-264-0791
www.osmc.com

OSMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, religion, pregnancy, sex, sexual orientation, gender identity, age, or disability.
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-398-2058.
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1- 800-398-2058。

WELCOME TO OUR OFFICE
PLEASE TELL US ABOUT YOURSEFL

Patient Information (please print)

Patient Name (Last) ________ **(First)** ________ **(M)** ____ | **Gender** ____ | **Birthdate** ____ | **Age** ____ | **Social Security Number** ________

Street Address ________________________________

Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced ____ Separated ____ Partner

City ________ **State** ________ **Zip** ________

Home Telephone: ( ) ________________ **Cell Phone:** ( ) ________________

Work Telephone: ( ) ________________ **Employer Name:** ________________

Referring Physician: ________________ **Primary Care Provider:** ________________

Person to Contact in Case of Emergency: ________________ **Phone:** ( )________________

Spouse/Parent Name: ________________ **Spouse/Parent Birthdate:** ________ **SSN:** ________

Spouse's Occupation & Employer: ________________ **Work Phone:** ( ) ________________

BRIEF DESCRIPTION OF INJURY / ACCIDENT / SYMPTOMS AND HOW IT OCCURRED

____

____

When did it occur? ________________________________

Location of Accident/Injury? Home: _______ **Work:** ______ **Autmobile:** _______ **Other:** ________________

If this accident or injury occurred at work, are you eligible for Worker's Compensation? __________ **Yes** __________ **No**

BILLING INFORMATION – PERSON RESPONSIBLE FOR FINANCES

If child or other than patient, who is responsible for the bill?

Name: ________________________________
(Last) **(First)** **(M)** **Social Security Number**

Address: ________________________________
City **State** **Zip**

Employer: ________________________________ **Work Phone:** ( ) ________________

INSURANCE INFORMATION

Please bring **Insurance Card(s)** to all appointments along with photo identification.

PLEASE COMPLETE OTHER SIDE

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