MID-ATLANTIC ORTHOPAEDIC SPECIALISTS, P.C.
PAIN and SPINE INSTITUTE
1120A PROFESSIONAL COURT
HAGERSTOWN, MD 21740
301-739-7900

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient is responsible for payment at the time of service when:

- **Patient is self -pay.**
- **Patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance.**
- **Patient has an insurance company that is nonparticipating with our office.**
- **Insurance requires a referral and patient does not provide one.**
- **Health insurance card or appropriate insurance information is not provided.**
- **Auto insurance information is not obtained prior to appointment.**
- **Worker's compensation insurance information/authorization is not obtained prior to appointment.**
- **Worker's compensation carrier is outside of the State of Maryland.**

All co-pays are due at the time of service.

Patient agrees to pay all charges promptly, including deductible and co-insurance.

A finance charge of 1.5% per month (annual rate of 18%) will be charged on unpaid patient due balances over 30 days.

Return-check-fee will be assessed for checks received for insufficient funds.

Patient /Guarantor will be responsible for any court costs and attorney fees for accounts placed with an attorney for unpaid balances.

I authorize Mid-Atlantic Orthopaedic Specialists, P.C./Pain and Spine Institute to submit medical claims to my insurance company.

I authorize payment of medical benefits to the provider of service.

I authorize Mid-Atlantic Orthopaedic Specialists, P.C./Pain and Spine Institute to treat me as needed.

I acknowledge receipt of the Privacy Notice, (available upon request).

___________________________________ **(SEAL)** ____________________________________

Signature **Date**

Patient under 18 years of age or incapacitated adult:

I, parent or legal guardian, authorize Mid-Atlantic Orthopaedic Specialists, P.C./Pain and Spine Institute to treat

_______________________________________.

Patient Name

I understand that I am fully responsible for this patient's medical expenses and agree to pay all charges for services rendered by the above named medical practice. I acknowledge receipt of the Privacy Notice.

___________________________________ **(SEAL)** ________________________________

Signature (Parent or Legal Guardian) **Date**

_____________________________________ ________________________________

Printed Name (Parent or Legal Guardian) **Relationship to Patient**