

**MID-ATLANTIC ORTHOPAEDIC SPECIALISTS, P.C.**  
**PROFESSIONAL SPORTS MEDICINE and REHABILITATION**  
**1120B PROFESSIONAL COURT**  
**HAGERSTOWN, MD 21740**  
**301-393-8730**

**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./Professional Sports Medicine and Rehabilitation 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./Professional Sports Medicine and Rehabilitation to treat me as needed.

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

\_\_\_\_\_  
Signature (SEAL)

\_\_\_\_\_  
Date

**Patient under 18 years of age or incapacitated adult:**

I, parent or legal guardian, authorize Mid-Atlantic Orthopaedic Specialists, P.C./Professional Sports Medicine and Rehabilitation 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.

\_\_\_\_\_  
Signature (Parent or Legal Guardian) (SEAL)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Parent or Legal Guardian)

\_\_\_\_\_  
Relationship to Patient