YOUR INSURANCE

In order for McNeil Orthopedics, Inc. to submit on your behalf to your insurance carrier, the assignment of benefits below needs to be completed. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, not with our office. It is your responsibility to pay deductibles, co-insurance, and any other balances in compliance with existing contractual agreements. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill.

HMO/PPO/COMMERCIAL INSURANCE SIGNATURE AGREEMENT

I request that the payment under my HMO/PPO/Commercial Insurance program be made on my behalf to McNeil Orthopedics, Inc. for services furnished to me by the provider. I further authorize McNeil Orthopedics, Inc. to release any information to determine benefits payable for related services.

REFERRAL

I understand that I am financially responsible for co-payments and/or deductibles in accordance with the provisions of my insurance plan. If covered under an HMO, I understand it is my responsibility to obtain a referral (when required). I further understand that if I do not obtain a referral when it is required by my plan, coverage for services may be denied by my HMO/PPO/Commercial Insurance and that it is my responsibility to make payment in full to McNeil Orthopedics, Inc. for those non-covered services. I have read this information and understand it.

This authorization is in effect for "1 YEAR from this Date: ___________________________

_______________________________ _______________________

Printed Name (Patient or Responsible Party) Patients Date of Birth

_______________________________ _______________________

Legal Signature (Patient or Responsible Party) Date Signed

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that the McNeil Orthopedics, Inc. Privacy Notice has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also displayed in the waiting room and on the McNeil Orthopedic, Inc. website www.mcneilorthopedics.com .

There may be instances that your healthcare provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another healthcare provider that may be consulted regarding your care or treatment. McNeil Orthopedics, Inc. cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow McNeil Orthopedics, Inc. to communicate my PHI electronically.

_______________________________ ________________ ______________

Patient or Personal Representative's Name Printed Relationship to Patient Patient's Date of Birth

_______________________________________ ___________________

Signature Date Signed

Documentation of Good Faith Effort

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

___ Patient refused to sign the Privacy Notice Acknowledgement

___ Patient was unable because:

____

____

___ There was a medical emergency. Provider will attempt to obtain acknowledgement when practical.

___ Other reason, describe: ____

_________________________ ___________________________ __________

Employee's Name Printed Employee's Signature Date