

HCA SPORTS MEDICINE OF VA

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PATIENT FINANCIAL AGREEMENT

1. \_\_\_\_\_ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, HCA Sports Medicine may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. \_\_\_\_\_ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that HCA Sports Medicine may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. \_\_\_\_\_ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to HCA Sports Medicine any insurance or other third-party benefits available for health care services provided to me. I understand HCA Sports Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to HCA Sports Medicine, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. \_\_\_\_\_ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to HCA Sports Medicine by the Medicare or Medicaid program.

5. \_\_\_\_\_ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for HCA Sports Medicine, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that HCA Sports Medicine or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or HCA Sports Medicine or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X \_\_\_\_\_ Date \_\_\_\_\_

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse          Parent          Guarantor          Legal Guardian          Healthcare Power of Attorney

Other (please specify) \_\_\_\_\_