Orthopaedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

PLEASE READ THIS THOROUGHLY AND CAREFULLY

If you are Workman's Comp, please disregard the Notification of Financial Responsibility and the Statement of Financial Responsibility, HOWEVER please review and sign the Release of Records to Insurance portion.**

Notification of Financial Responsibility

All patients are financially responsible for the payment of services rendered by Michael M. Heckman M.D. Payment is expected at the time services are rendered, unless arrangements are made prior to the visit. This includes co-pays, deductibles and coinsurance. There is also a responsibility to provide payment for any remaining account balances, there may be on your account.

If payment is not rendered for your account, interest will begin to accumulate. After 90 days of overdue payments. A **12% interest rate will be added to the past due balance.** After 120 days, your account will be sent to a collection agency and there will be a **35% collection fee added to your existing balance.** All return checks will result in a $25.00 charge to your account.

Statement of Financial Responsibility

I have carefully read and understand that I_____ am financially responsible for the payment of all charges pertaining to the services rendered by Michael M. Heckman M.D.

Guarantee of Payment

Please Initials

_____ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

_____ I have been advised that if my health insurance carrier/PPO/HMO/Medicare plan claims that the services I received today are not conserved reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize the services that I am requesting and receiving today. I have been advised that if I did not notify my PCP in advance for a referral authorization my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I understand that if my insurance company does not deem the services I received as "a covered benefit" I will be responsible for payment of these services.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. If insurance does not pay in a timely manner (within 90 days of the date of insurance filing) the guarantor will be expected to pay the balance and then pursue reimbursement from the insurance company.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guarantor (If patient is a minor/indigent) Date

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