GRAHAM
MEDICAL ASSOCIATES

_____FINANCIAL RESPONSIBILITY AGREEMENT:
Initials

I agree to assign insurance benefits to Graham Medical Associates. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. I acknowledge full financial responsibility for services rendered by Graham Medical Associates and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize all insurance payments to be made directly to Graham Medical Associates. Payment is expected at the time of service. We will file your insurance as a courtesy to you. If your deductible has not been met and/or you are responsible for a co-payment under your plan, we will expect the payment of such upon delivery of services and immediately upon the end of your visit. There will be a $30 fee for returned checks.

_____PATIENT PRIVACY PRACTICES:
Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____CONSENT OF TREATMENT:
Initials

I authorize Graham Medical Associates to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

_____TELEPHONE CONSUMER PROTECTION ACT (TCPA):
Initials

I agree that the facility, Graham Medical Associates or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

_____PROOF AND CHANGE OF INSURANCE:
Initials

Patients are required to show both proof of insurance and a Government issued photo ID at their initial and subsequent visits. The patient (parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid having to reschedule your appointment.

_____DISABILITY PAPERWORK/MISSED APPOINTMENT POLICY/RADIOLOGY AND LAB FEES:
Initials

Please give all forms regarding disability to the nursing staff. Please do not give these forms to the physician. Please note that there is a $25 completion fee per form. You will need to expect 72 hours for these forms to be completed. Fill out the portion of the disability form that is for the patient and leave physician's area blank.

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A $50 fee may be charged for a no show or late cancellation of appointments. Payment of this fee is the responsibility of the patient and is not covered by insurance.
You may incur additional charges from providers outside your network for procedures done outside of our facility that may be part of your surgical procedure or radiological exam. This can include pathology, radiology and/or lab fees.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for Graham Medical Associates. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Graham Medical Associates to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Physician's Consent" and the "Disclosure of Financial Interest".
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X_____ _____
Patient or Guardian Signature Date

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-123-456-7890 (TTY: 1-123-456-7891).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-123-456-7890 (TTY: 1-123-456-7891).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-123-456-7890（TTY：1-123-456-7891）。