

HAND AND MICROSURGERY ASSOCIATES, INC.

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Financial Policy, Consent to Treat, and Privacy Policy

I agree and give my consent for Hand and Microsurgery Associates and Columbus Hand Therapy (HMA-CHT) to furnish medical care necessary to diagnose and treat my condition.

I assign all benefits I am entitled to from any third party payer including insurance companies and courts to HMA-CHT. In order to secure payment I authorize all third parties to provide any and all information necessary to assist HMA-CHT in securing payment.

Your insurance policy is a contract between you and your insurance company. It is your responsibility to contact your insurance company in order to understand what your insurance company will pay and to secure payment. It is essential that you understand your specific group's coverage. Our participation or non participation is not a guarantee of coverage or payment. It is our policy that patients are ultimately responsible for all services regardless of coverage. I do understand my insurance is out of network.

Patient Signature

Out of Network Insurance Reviewed by: _____
Employee Signature

Patient Requested review of Financial Policy with a Billing Specialist. _____
Billing Specialist Signature

We bill third party payers including insurance companies solely as a courtesy. You are responsible for all non-covered services, co-pays and deductibles at the time services are rendered. If Surgery is scheduled a Billing Specialist will review your out of pocket expenses that are required prior to Surgery. If there is an outstanding balance on your account for HMA-CHT after 90 days your account(s) will be subject to a monthly administrative fee. If your insurance company does not pay HMA-CHT within 90 days, any outstanding balance is due by you. If your company or other third party payer pays on a fee schedule that is less than HMA-CHT fees you will be responsible for the remaining balance unless HMA-CHT is a participating provider. Your signature below acknowledges your legal and financial obligation including immediately turning over any monies paid to you by third parties including insurance companies and courts to HMA-CHT. You understand that if monthly payment arrangements have been approved, all monies forwarded from third party payers does not apply toward this monthly payment plan. The foregoing may not apply to Workers Compensation patient, however, if your Workers Compensation claim is disallowed charges for treatment will be your personal responsibility.

When you pay for services by check and your bank for any reason does not honor your check you authorize HMA-CHT to electronically debit your bank account(s) for the amount of the check plus a processing fee up to the State legal maximum. I also agree that if I fail to make any payments for which I am responsible in a timely manner. I will be responsible for all associate costs related to HMA-CHT efforts to collect these fees including attorney fees, court costs and collection agency fees over and above the amount of the bill for services provided.

Hand and Microsurgery Associates Inc, and Columbus Hand Therapy will be charging \$35.00 for a cancellation not received 24 hours ahead of time and patients who do not show up for their appointment.
Hand and Microsurgery Associates will assess a charge for all forms that need to be completed by our staff, excluding BWC, Social Security, and Medicare forms: A \$10.00 charge for all single page forms, \$25.00 for multiple page forms, these charges are per request. All fees will be collected up front before forms will be completed. If forms are mailed, you will be contacted for payment before the forms will be completed.

I authorize HMA-CHT to use and disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detail information about how we use and disclose PHI. You have the legal right to review our Notice of Privacy Practices before you sign this consent. You have a right to request us to restrict how we use and disclose your PHI. We are not required by law to grant your request however if we grant your request we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your prior consent. You may also direct us to release your PHI to another person such as your spouse, adult child, etc.

A billing specialist will be available for you to speak with prior to your appointment to discuss insurance payments, and any other questions or concerns that you may have.

Patient Signature:

_____/_____/_____
Date:

Printed Name:

Legal Guardian Signature:

_____/_____/_____
Date PtPkts/FinConsentHippaAgree 8/26/2010