

**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 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

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 your insurance company does not pay HMA-CHT within 60 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.

I authorize HMA-CMT 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:

\_\_\_\_\_  
Printed Name:

\_\_\_\_\_  
Relationship to patient: