



## AGREEMENT FOR ASSIGNMENT OF BENEFITS

1. **Insurance:** I hereby authorize and assign benefits and direct payment under any applicable insurance policy to be made on my behalf to the Bone & Joint Center (Bone & Clinic, S.C. and/or BJOSC, LLC) for any services rendered to me by the Bone & Joint Center. I understand that unless I pay for services rendered to me by the Bone & Joint Center in full, out of pocket, and request that the information not be released, the Bone & Joint Center may release to my insurance or workers' compensation carrier any information or diagnoses and records of any treatment needed for the purpose of determining benefits for payment of services rendered to me.
2. **Self-Pay (Cash Pricing):** In the event my private health insurance is not accepted at Bone & Joint Center, or if I request to not have my insurance billed, I agree to self-pay for care. Bone & Joint Center will comply with all requirements for good faith estimates. My insurance will not be billed, and I will be responsible for the full amount of the cash price offered to me. I understand discounted cash pricing will not be offered by Bone & Joint Center for claims submitted to my insurance, even if those claims are denied. I further understand that if a claim is submitted to my insurance and is denied, I will be responsible for the full price of such claim, based on Bone & Joint Center's regular fee schedule and will not receive the cash pay discount. I therefore specifically request that Bone & Joint Center not submit a claim to my insurance if it is known to Bone & Joint Center that Bone & Joint Center is not in network with my plan unless I request otherwise in writing.
3. **Medication History:** I understand the Bone & Joint Center may obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.
4. **Disclosure of Health Information for Routine Health Care Operations:** I understand the Bone & Joint Center participates in one or more Organized Health Care Arrangements and that members of the Organized Health Care Arrangements may share medical information with each other for treatment, payment, or health care operations purposes.
5. **Photo and Video Prohibition:** To protect the privacy of all patients, photo or video recordings by the patient or any accompanying party within the patient care areas is strictly prohibited.
6. **Patient Opt-In:** By supplying phone numbers (including my mobile phone number), email address and any other personal contact information, I authorize the Bone & Joint Center, or a business associate of theirs, to contact me at any of the numbers or email addresses using an automatic telephone dialing system, using pre-recorded voice or other 3rd party automated outreach and messaging system as well as to use my protected health information, or other personal or identifying information, during such contact for any administrative or healthcare matter. I consent to the Bone & Joint Center, or their business associate contacting me via unencrypted email and text messages. I also agree that they may leave detailed messages on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. To opt out of or modify any of these communications, please contact the Bone & Joint Center at any time.
7. **Worker's Compensation:** In the event a workers compensation carrier denies my claim or service, and/or in the event my medical provider opines my condition is not related to my work injury claim, I agree to pay any and all applicable charges for services at the Bone & Joint Center that are not covered by my insurance policy, including, but not limited to, charges that exceed my benefit level, co-payments, co-insurance, and/or deductible amounts.
8. **Credit Balance:** I agree to have a credit balance on my account transferred and applied to any account with an outstanding balance due to the Bone & Joint Center. Any credit balance remaining after the transfer will be refunded to me.
9. **Payment of Personal Responsibility Amounts:** I agree to pay all charges for services at the Bone & Joint Center that are not covered by my insurance policy, including, but not limited to, charges that exceed my benefit level, co-payments, co-insurance and/or deductible amounts.
10. **Acknowledgement of Receipt of Notice of Privacy Practice (NPP):** I acknowledge that a copy of the written Bone & Joint Clinic, S.C. "Notice of Privacy Practices" has been provided to me. The NPP is also available on the Bone & Joint website.

Printed Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized Representative Signature:**

Printed Name of Authorized Representative: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Signing:  Patient is a minor  Patient has a legal guardian  Patient has an activated Power of Attorney