Financial Policy for
Asheville Regenerative Orthopedics & Sports Medicine PLLC

ADDITIONAL CHARGES

- No Show Charge **$25.00** if not notified within 24 hours prior to your appointment.
- Completion of Forms may be subject to an additional charge.

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Asheville Regenerative Orthopedics & Sports Medicine PLLC any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Asheville Regenerative Orthopedics & Sports Medicine PLLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Asheville Regenerative Orthopedics & Sports Medicine PLLC, I am not responsible for amounts she has agreed to write-off per the contract. If my insurance does not have a contract with Asheville Regenerative Orthopedics & Sports Medicine PLLC I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Asheville Regenerative Orthopedics & Sports Medicine PLLC.

_____ _____

Patient's Name Printed Patient's Date of Birth

_____ _____

Patient's Signature Date

_____ _____

Responsible Party Signature Relationship to Patient