Comprehensive Orthopaedics of the Gulf Coast

Please review the following patient responsibilities, sign and return.

OBLIGATION TO PAY MY BILL: I understand that all charges for services rendered by Comprehensive Orthopaedics of the Gulf Coast are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my COGC bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance plan, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I acknowledge that billing my health plan is a service provided by COGC. I will inform COGC of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire COGC bill if my health plan refuses to pay after reasonable attempts to collect from the health plan.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be re-scheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance will result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my health plan requires pre-authorizations for tests or for referrals to specialists. I understand the COGC office staff may assist me with scheduling referrals and/or diagnostic testing but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write to COGC and will pay these fees upon notice.

NON-PAYMENT ON ACCOUNT: I understand that if my COGC account has a balance due older than 90 days old, it may be placed with an outside agency for collection and all relevant personal and account information necessary to collect payment for services will be revealed. I understand that I am responsible for all fees for collecting these past due balances including, but not limited to, collection fees, court costs and attorney fees. I understand COGC may, upon written notice, terminate the patient / physician relationship due to non-payment on account.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need. I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider. I agree to carefully read all stipulations in the narcotics agreement and abide by these. I understand that my physician will refill narcotics only when appropriate and/or only during the office visit.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There is also a nominal fee of $30.00, payable in advance, for the completion of these forms. I understand these requests may take up to 14 business days for processing.

MEDICAL RECORDS: I understand that in compliance with applicable state and federal law, in some cases, appropriate authorization forms must be completed and signed by the patient before records are released. Florida law allows office practices to charge a fee for providing these medical records to cover labor, equipment and supplies, which will be collected prior to the release of medical records.

PATIENT PORTAL: I understand COGC has a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the Patient Portal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to COGC to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from COGC and their authorized agents.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Guardian Signature:_____

Date:_____

Print Patient/Guardian's Name from above:_____

Guardian's relationship to patient:_____