

ABOUT MEDICAL INSURANCE & FINANCIAL ARRANGEMENTS

NOTICE OF PRIVACY MATTERS

ADVANCED SPORTSMEDICINE CENTER
JOHN T. MOOR, M.D. - JOHN A. GARCIA, M.D.

Insurance claims may be filed for you as a courtesy of this office. Required are your valid insurance card and photo I.D. to process insurance claims. Our registration form represents the minimum information required by your insurance company to process your claim. *You may file your own insurance claim if you desire by paying in full at the time of your visit.* We accept Cash, Check, VISA and MASTERCARD. Your cooperation with payment in full when services are rendered is appreciated.

We have chosen to participate with **Medicare** and therefore accept assignment on Medicare claims. While Medicare pays less than usual and customary fees, your responsibility is still limited to a yearly \$131 deductible and a 20% co-payment. Medicare 20% co-payments are required at the time of service if supplemental insurance is not available. **Private insurance** is a contract between you and your insurance company only. We are not a party to that contract. Our fees are average for this area and are therefore considered usual, customary, and reasonable by most companies. Some insurers reserve the right to cover only their arbitrary payment schedule and percentage of fees on your behalf. Not all services are covered benefits in all contracts. We have no way of determining what your specific policy covers as there is wide variability between carriers. Only your insurance company knows which services and to what extent you are covered under your contract. **Managed care** (HMO, PPC, PPO, etc.) programs often require referral authorizations from the primary care doctor. Associated co-payments are due in the amount required by the individual policies. **Worker's Compensation** requires prior approval from their insurance carrier before medical evaluation can be initiated. Worker's Compensation insurance is responsible for 100% of your medical bill, but only regarding your work related injury. **Auto insurance** is not guaranteed coverage. Thereby payment in full at the time of services rendered is required. Your insurance company may be billed upon request as a courtesy of this office to facilitate your reimbursement.

The undersigned assumes responsibility for payment to John T. Moor, M.D., P.A. and understands that any amounts owed, but not paid by insurance carriers or other third parties, will be the responsibility of the undersigned. With respect thereto, the undersigned authorizes payment of all insurance benefits to John T. Moor, M.D., P.A., consents to the release of any information necessary to facilitate collection, and authorizes the release of medical records to other providers as deemed reasonable by the above doctors. The undersigned will be responsible for an additional 1/3 (33.3%) of the outstanding balance and/or reasonable fees of an attorney if collection costs are incurred. Credit reports are hereby authorized. Interest may accrue on unpaid balances at the rate of 18.0% per annum.

ASSIGNMENT AUTHORIZATION: I authorize the release of medical information necessary to process insurance claims as is pertinent to my medical care. I authorize assignment of all medical and/or surgical benefits to John T. Moor, M.D., P.A. A photocopy of this assignment is to be considered as valid as the original.

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or the billing agencies of *JOHN T. MOOR, M.D., P.A.* any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

HIPPA Notice: Medical record information may be used in performing quality improvement, reviewing qualifications of healthcare professionals, insurance activities such as underwriting and premium rating, conducting medical reviews or legal services or auditing functions including fraud detection compliance programs, and general administration including but not limited to compliance and customer service and internal grievances. Additional HIPPA compliance notification information is available on request by asking to speak with the privacy officer/administrator if you have any questions.

I give my permission for Advanced Sportsmedicine to call and leave a message regarding confirmation and rescheduling of an appointment.

I, the undersigned, have reviewed and understand this agreement, and for valid consideration, agree to guarantee payment of all amounts owed by the patient now or in the future in consideration of the services provided by John T. Moor, M.D., P.A.

"Guarantor"(printed) _____

Signature _____ Date _____