ORTHOPAEDIC SPECIALTY GROUP, P.C.

Exceptional People. Exceptional Care.

INSURANCE DISCLOSURE, PAYMENT AGREEMENT, AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RELEASE OF MEDICAL RECORDS FILMS AND CD'S

I_____(Please print full name)
Understand that it is my responsibility to provide accurate and current demographic and financial information on the date of service. If I do not provide a copy of my insurance card on the date of service, I will be responsible for payment of medical services provided. I also understand that I am personally responsible for payment of medical services rendered should insurance coverage be declined or denied by my insurance provider as a result of any delay in providing correct insurance information/billing information. I further agree as patient, parent, legal guardian or guarantor in the event of default, to pay all cost of collection, including attorney fees, collection agency effort fees, and contingent fees to collection agencies of not less than 40%, such contingency fees to be added and collected by the collection agency we have secured immediately upon your default and our referral of your account to said collection agency.

Important Information Regarding Finance Charge

A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to your account. The Finance Charge will be computed at the rate of one percent (1%) per month or an Annual Percentage Rate of twelve percent (12%).

The signature below also indicates I have either reviewed or received a Notice of Privacy Practices. I authorize OSG MRI to use or disclose my Protected Health Information (PHI) in any manner outlined in their Notice of Privacy Practices.

I authorize the release of Records, CD's or Films, to my physicians, for diagnosis, treatment and reimbursement for services.

*~This signature will be valid for **only 120 days**, for release of records, CD's and Films.~*

Signature: _____ **Date:** _____

(Relationship: Patient, Parent, Guardian) _____

Email (please print): _____
(Email information is for OSG MRI use only; it will not be shared with anyone.)