ORTHOPAEDIC MEDICAL GROUP
Stuart A. Goldsmith, M.D.

Insurance:

THIS OFFICE WILL FILE YOUR INSURANCE FOR CONTRACTED INSURANCE COMPANIES, OTHER INSURANCE WILL BE FILED AS A COURTESY FOR HOSPITAL CHARGES ONLY. FORTY FIVE DAYS AFTER FILING, IF WE HAVE NOT HEARD FROM YOUR INSURANCE YOU ARE THEN RESPONSIBLE FOR THE ENTIRE BALANCE.

HMO & PPO Insurance:

THE PATIENT IS RESPONSIBLE FOR THE CO-PAYMENT AT THE TIME SERVICES ARE RENDERED.

Medicare:

PATIENTS WITH MEDICARE MUST PROVIDE PROOF. THE DEDUCTIBLE HAS BEEN MET, AND WILL BE RESPONSIBLE FOR 20% AT THE TIME SERVICES ARE RENDERED UNLESS THERE IS A SUPPLEMENT TO MEDICARE.

THIS IS TO CERTIFY I FULLY UNDERSTAND THE OFFICE POLICY AS OUTLINED ABOVE.

Medical Information:

I GIVE MY PERMISSION FOR STUART A. GOLDSMITH, M.D. OR THE OFFICE STAFF TO GIVE INFORMATION REGARDING MY MEDICAL STATUS, MEDICATIONS, X-RAYS RESULTS, STATUS OF MY ACCOUNT, ETC.: TO MY REFERRING PHYSICIAN AND/PR INSURANCE COMPANY.

EXPIRATION DATE: ______________ ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Assignment of Benefits:

I HEREBY AUTHORIZE PAYMENT BE MADE DIRECTLY TO STUART A. GOLDSMITH, M.D.. FOR ANY MEDICAL OR SURGICAL BENEFITS UNDER MY INSURANCE PLAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE FOR PROFESSIONAL SERVICES IN EXCESS OF THE BENEFITS PROVIDED BY MY INSURANCE.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Records & X-Ray Policy Release:

IT IS THE POLICY OF THIS OFFICE NOT TO RELEASE X-RAYS OR MEDICAL RECORDS WITHOUT THE AUTHORIZATION FROM DR. GOLDSMITH.

WHEN REQUESTING COPIES OF MEDICAL RECORDS AND/OR X-RAYS PLEASE ALLOW 5 TO 7 DAYS NOTICE. THERE WILL BE A FEE OF $10.00 PER X-RAY AND $1.00 PER PAGE FOR MEDICAL RECORDS. THIS FEE MUST BE PAID PRIOR TO RECEIVING ANY COPIES.

Disability and Other Medical Forms:

PLEASE ALLOW 7 TO 10 DAYS FOR COMPLETION. THE FORM WILL NOT BE COMPLETED AT THE TIME RECEIVED. A FEE OF $25.00 PER FORM AND IS PAYABLE IN ADVANCE.

Durable Medical Equipment:

CAST BOOT, SLINGS, ETC.: ARE NOT ALWAYS COVERED BY YOUR INSURANCE, THE PATIENT OR RESPONSIBLE PARTY WILL BE ASKED TO PAY FOR THESE GOODS AT THE TIME SERVICES ARE RENDERED.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY