

Orthopaedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

****PLEASE READ THIS THOROUGHLY AND CAREFULLY****

****If you are Workman's Comp, please disregard the Notification of Financial Responsibility and the Statement of Financial Responsibility, HOWEVER please review and sign the Release of Records to Insurance portion.****

Notification of Financial Responsibility

All patients are financially responsible for the payment of services rendered by Dr. Michael M. Heckman M.D., P.A. Payment is expected at the time services are rendered, unless arrangements are made prior to the visit. This includes, co-pays, deductibles and coinsurance. There is also a responsibility to provide payment for any remaining account balances, there may be on your account.

If payment is not rendered for your account, interest will begin to accumulate. After 90 days of overdue payments. An 18% interest rate will be added to the past due balance. After 120 days, your account will be sent to a collection agency and there will be a 30% collection fee added to your existing balance.

Statement of Financial Responsibility

I have carefully read and understand that I _____ am financially responsible for the payment of all charges pertaining to the services rendered by Dr. Michael M. Heckman M.D., P.A.

Signature of Patient

Date

Signature of Guarantor (If patient is a minor/indigent)

Date

Release of Records to Insurance

I authorize Orthopaedic Knee Shoulder & Sports Surgery to release any information, including but not limited to, diagnosis and records of any treatment rendered in order to receive payment from the insurance company.

Signature of Patient

Date

Signature of Guarantor (If patient is a minor/indigent)

Date