SOUTH BEND ORTHOPAEDICS
A DIVISION OF ASCENDANT ORTHOPEDIC ALLIANCE, LLC

**Agreement to Pay and Benefit Assignment**

I agree to pay for all services and charges rendered to me by South Bend Orthopaedics, A Division of Ascendant Orthopedic Alliance, LLC. (South Bend Orthopaedics), physician and/or other qualified healthcare provider employed by South Bend Orthopaedics. I agree that I am responsible to provide timely information about my insurance coverage, any changes in coverage and respond promptly to requests for information as they occur.

I assign to South Bend Orthopaedics benefits (including rights under the Employee Retirement Income Security Act of 1974) due to me or become due to me as a result of the medical services I receive from South Bend Orthopaedics physicians or other qualified healthcare provider to pursue any health insurer, third party administrator, health plan (insured or self-funded) for payment provided directly or indirectly by South Bend Orthopaedics. This includes any right to appeal any part of any claim denied or partially paid and to file any administrative or legal proceeding to pursue payment. I further assign South Bend Orthopaedics all rights to obtain plan documents, summary plan descriptions and health insurance related policy documents. I further authorize the payments to be paid directly to South Bend Orthopaedics. I understand that I am responsible to South Bend Orthopaedics for any payments made directly to me for services South Bend Orthopaedics provided to me. If this account is not paid in accordance with South Bend Orthopaedics's policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees and interest from the date of demand.

**Telephone Consumer Protection Act(TCPA) Consent**: I give my expressed consent to South Bend Orthopaedics and any of its agents in order to service my account or to collect any amount I owe they may contact me by telephone, at any telephone number associated with this or any other account held by South Bend Orthopaedics including wireless telephone numbers, which could result in charges to me. South Bend Orthopaedics and any of its agents, may also contact me by sending text message or e-mails or pages using any e-mail address I provide to South Bend Orthopaedics or agents. Methods of contact may include using pre-recorded and/or artificial voice messages and/or use of an automatic dialing device, as applicable.

**Financial Responsibility**: Additionally, I agree to pay all charges and account balances that are not paid in full by the assigned insurance company or third party payer. I understand that payment is immediately due when Services are rendered. If amounts due to the Healthcare Providers are not paid after reasonable notice and Healthcare Provider's efforts to collect, then the account will be considered delinquent – and additional service charges may be added to the account balance to offset additional incurred collection expenses. In the event that I avoid or refuse to pay or that I default on agreed payment arrangements and terms, I understand that I will be responsible for any and all reasonable attorneys' and legal fees, court costs, and incurred collection costs and expenses. If the debt is assigned to a third party collection service, then I agree to be responsible for the collection fees and interest as allowed by Indiana statute on the outstanding debt. I understand that debts referred to a third party for collection will be reported to credit reporting entities and will be reflected in my personal credit file and history. If a check payment is returned for any reason, a $15 NSF will be applied to the patient's account. If you present two checks that are returned to us, we will require cash or card payments for any future services.

**Minor Patients:** A parent or legal guardian must accompany patients 17 years old and younger and sign as responsible party below (Exception: patients 17 years and younger declared emancipated minors). It is the parent or guardian's responsibility to bring the necessary referrals, insurance card(s) and to make payment at the time of service. Our physicians will recommend medically appropriate treatment for the patient. In the event your health plan deems a service(s) medically unnecessary, experimental, non-covered and/or inclusive, as responsible party you agree to pay for any amounts not covered by the carrier.

We do accept **Workers Compensation** patients and file all claims to the carrier. There will be no balance billing to the patient for approved cases. Should workers compensation deny your claim the patient is responsible for payment in full. South Bend Orthopaedics will not knowingly collect or attempt to collect the payment of a charge for medical services or products covered under Ind. Code§ 22 from a patient or the patient's estate or family members.

I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account. Account balances after insurance must be paid in full within 30 days of patient billing, unless other payment arrangements have been made to avoid collection agency action.

**Fees**:

**DISABILITY:** There will be a fifteen dollar ($15) charge for each disability form and a seven to ten (7-10) BUSINESS day waiting period for all disability forms.

**FAMILY MEDICAL LEAVE ACT FORMS:** There will be a fifteen dollar ($15) charge for FMLA paperwork and a seven to ten (7-10) BUSINESS day waiting period.

**HANDICAP PARKING PERMITS:** No charge.

**MEDICAL RECORDS COPYING FEES:** Payment is due prior to mailing or at the time of pick up.

- Six dollar and fifty cents ($6.50) for all records on paper regardless of the number of pages requested.
- Six dollar and fifty cents ($6.50) per CD (X-Ray/MRI/Medical Records)
- Requests to be provided within 48-72 hours will be processed with an additional ten dollar ($10) fee.

_____
Printed Name of Patient/Guardian/Personal Representative

_____
Other Authorized Person (Relationship to Patient)

_____ _____ _____
Signature of Patient/Guardian/Personal Representative | Date | Employee Witness

SOUTH BEND ORTHOPAEDICS
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**Notice of Financial Interest in Health Care Entity**

In addition to the above, I acknowledge with my signature below that my treating physician and/or other physicians at South Bend Orthopaedics, A Division of Ascendant Orthopedic Alliance, LLC. (South Bend Orthopaedics), is/are a part-owner(s) of South Bend Orthopaedics, South Bend Orthopaedics Therapy, South Bend Orthopaedics MRI, Unity Medical & Surgical Hospital and Allied Physicians Surgery Center. The physicians believe these facilities are an appropriate setting for your medical care. Nevertheless, the selection of a specific health care provider always rests with the patient, and you may choose to be referred to an alternate setting if you so desire. Your signature below indicates your receipt and understanding of this information.

**Consent to Treatment**

I consent to the administration of health care by South Bend Orthopaedics This consent to treatment includes the administration of health care by the physicians employed by or associated with South Bend Orthopaedics and such assistants, residents, interns, students, or other medical personnel as may be selected and supervised by said South Bend Orthopaedics physicians. I understand that I may set condition or limitations on my treatment and care and that if I wish to provide such conditions, I will be given an opportunity to write those in a separate document.

I understand that during the course of treatment, my blood or bodily fluids may come in contact with a care giver. Upon such an exposure incident testing may be necessary to determine my Hepatitis and HIV status and I give my consent for such testing.

I am giving my consent to the administration of health care by South Bend Orthopaedics voluntarily. I have been informed and acknowledge that I may withdraw my Consent to Treatment at any time upon written notice to South Bend Orthopaedics. I hereby knowingly and voluntarily enter into this Consent to Treatment.

By my signature below, I am acknowledging receipt of a copy of this document and agree to the terms under all sections of this document: Agreement to Pay and Benefit Assignment, Notice of Financial Interest in Health Care Entity, Consent to Treatment, and Acknowledgment of Receipt of HIPAA Privacy Policies.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Guardian/Personal Representative | Date | Employee Witness |

**Acknowledgement of Receipt of HIPAA Privacy Policies**

The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and I have the right to request new copies at any South Bend Orthopaedics location during regular business hours.

I have been given an opportunity to review the Notice of Privacy Practices ☐ No ☐ Yes _____ Initials

I give South Bend Orthopaedics my approval to access my electronic prescription drug history ☐ No ☐ Yes _____ Initials

**Medicare Statement**

I request that payment of authorized Medicare benefits be made to South Bend Orthopaedics, A Division of Ascendant Orthopedic Alliance, LLC. (South Bend Orthopaedics), on my behalf for any services furnished to me by South Bend Orthopaedics. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits related services.

Patient: _____ Date _____

**Medigap Statement**

I request that payment of authorized Medigap benefits be made to South Bend Orthopaedics, A Division of Ascendant Orthopedic Alliance, LLC. (South Bend Orthopaedics), for any services furnished to me by South Bend Orthopaedics. I authorize any holder of medical information about me to release to my Medigap insurer - _____ any information needed to determine these benefits or the benefits payable for related services.

Patient: _____ Date _____