



COLUMBUS
**ORTHOPEDIC &
 SPORTS MEDICINE**
 CLINIC, P.C.

**Richard R. Cimpl, M.D.
 Kelli K. Thomazin PA-C**

Patient Name: _____

Date of Birth: _____

Thank you for choosing Columbus Orthopedic & Sports Medicine Clinic, P.C. The following is a statement of our FINANCIAL POLICY. Full payment of your bill is considered a part of your treatment.

ALL CO-PAYS ARE DUE PRIOR TO TREATMENT

METHOD OF PAYMENT: We accept CASH, CHECK, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS. Payment plans may be arranged on an individual basis with the Billing Department in our office.

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after processing of our claim by your carrier is your responsibility.** Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information for commercial insurance, Medicare and Nebraska Medicaid. It is your responsibility to know your insurance benefits, as it may not cover all of the services provided to you.

MVA POLICY: Columbus Orthopedic & Sports Medicine Clinic, P.C. will bill your MVA claim to a third party insurance carrier. You will be asked for your personal insurance information for the purpose that should your motor vehicle insurance benefit for this claim become exhausted, we will bill your personal insurance. If insurance has not paid this claim within 120 days of the date of service to you, you will become personally responsible for the amount due.

REGARDING WORK-RELATED INJURIES: We will file Workers Compensation claims with your employer's Workers Compensation insurance carrier. You will be asked for your personal insurance information for the purpose that should your employer deny this claim, we will bill your personal insurance. If your company's workers compensation carrier has not paid your account in full within 120 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

X _____
SIGNATURE of Patient or Responsible Party

_____/_____/_____
DATE

Privacy Notice Written Acknowledgement

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I received Columbus Orthopedic & Sports Medicine Clinic Notice of Privacy Practice. Your signature does not indicate that you have read or agree with the information contained in the Notice, only that you have received it. Should you have any questions about the Notice or our practice, please contact the office manager at the number indicated on the Notice.

Signature of Patient/Legal Guardian

_____/_____/_____
Date

Witness _____