MOUNT NITTANY PHYSICIAN GROUP

FINANCIAL AGREEMENT
ORTHOPEDICS

FINANCIAL POLICY: The following is our Financial Policy. Please review carefully, and **sign when checking in** for your appointment.

INSURANCE/INCLUDING MEDICARE: Your insurance policy is a contract between you and your insurance company. We will bill your insurance company for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for any deductibles, co-pays, co-insurances, or non- covered services your contract requires.

SECONDARY INSURANCE: As a courtesy, we will bill your secondary insurance as long as you provide us with the correct and current information. You are ultimately responsible for any deductibles, co-pays, co-insurances, or non-covered services your contract requires.

AGREEMENT: I request payment of authorized benefits to be made on my behalf to Mount Nittany Physician Group Orthopedics for services rendered to me. I understand that by my signature below, I am requesting payment be made and authorizing release of medical information as necessary to determine payment. My signature below authorized release of information to secondary insurers as well as primary in determining payment of a claim. I understand I am responsible for deductibles, co-pays, co-insurances, and non-covered services. I understand that ultimately I am responsible for all health services rendered to me. I understand and agree to the conditions of this policy.

WORKER'S COMPENSATION/AUTO ACCIDENT CLAIMS: We request your private insurance information at the time of services as well as the claim information. In the event your third party claim is not accepted, or has been exhausted, we will bill your private insurance. You are ultimately responsible for any deductibles, co-pays, so-insurances, or non-covered services your contract requires.

AGREEMENT: I request payment of authorized benefits be made on my behalf to Mount Nittany Physician Group Orthopedics for services rendered to me. I understand that by my signature below, I am requesting payment be made and authorizing release of medical information necessary to determine payment. My signature below authorized release of information to secondary insurers as well as primary in determining payment of a claim. I understand that I am responsible for deductibles, co-pays, co-insurances, and non-covered services. I understand that ultimately I am responsible for all health services rendered to me. I understand and agree to the conditions of this policy.

Patient Print Name:_____**DOB:**_____
Patient Signature:_____ **Date:** (mm/dd/yyyy) _____
(Or Responsible Party)