

Financial Policy Consent Form

I have been provided with a complete copy of the Financial Policy for Perimeter Orthopaedics, P.C. and Perimeter Outpatient Surgical Assoc, Inc. I also agree that the original copy of this financial policy consent form will become a legal document in my patient file(s). I understand that at any time, I may be provided with a copy of the entire Financial Policy upon request.

I have read, understand, and agree to comply with all the above Financial Policies. I understand that payment for any known non-covered charges by my insurance company may be required at the time of visit; otherwise I will be billed at a later date. I am also responsible for all applicable co-payments and deductibles at the time services are rendered.

This financial policy will supersede any previous financial policies that may be on file with our office.

I authorize my insurance benefits be paid directly to Perimeter Orthopaedics, P.C.; (Tax ID # 58-1646346) and/or Perimeter Outpatient Surgical Associates, Inc.; (Tax ID#58-2430839).

I authorize Perimeter Orthopaedics, P.C. and/or Perimeter Outpatient Surgical Associates, Inc. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim as it complies with HIPAA guidelines.

Date **Patient or Guardian Signature** _____
Printed Name

Date **Employee Signature** _____
Printed Name