SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Litchfield Hills Orthopedic Associates, LLP

SPECIALIZED CARE YOU CAN TRUST

www.LHOA.com

Patient Name: ______________________________ Date of Birth: ____________________

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my insurance plan.
2. My insurance plan requires that I pay a deductible, co-payment, or co-insurance.
3. Charges are not paid because I have failed to provide current and valid insurance policy information.
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. Payment be made to Litchfield Hills Orthopedic Associates, LLP, (LHOA) by my insurance carrier for services rendered or product received.
2. LHOA may use and disclose medical information about me for services rendered or product received.
3. To pay for my co-pay and any other charges that are not covered by my insurance plan today or make financial arrangements satisfactory to LHOA for payment.
4. To pay for any returned check fees incurred by LHOA.
5. If I am the parent/guardian bringing a child in for treatment, that I am responsible for all fees incurred by the child.
6. To pay collection expenses and attorney fees if my account is sent to the collection agency or to an attorney for collection.

______________________________ ____________________

Patient Signature Date

Litchfield Hills Orthopedic Associates, LLP, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.