

# Rockingham Orthopaedic Associates

## **AUTHORIZATION FOR THE RELEASE OF MEDICAL/FINANCIAL INFORMATION:**

I authorize Rockingham Orthopaedic, LLC to release any medical/financial information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care. Also included are:

\_\_\_\_\_ Relationship \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_

## **ASSIGNMENT OF INSURANCE BENEFITS:**

I authorize payment of benefits to be paid directly to Rockingham Orthopaedic, LLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including collection and attorney fees.

## **HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA):**

I have certain rights to privacy regarding my protected health information. Rockingham Orthopaedic Associates' Notice of Privacy Practices has been made available to me, containing a more complete description of the uses & disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of this notice.

## **MISSED APPOINTMENTS:**

When a patient fails to keep an appointment, we have the right to charge a fee for the missed appointment. To avoid missed appointment fees, the patient must notify Rockingham Orthopaedic, LLC in advance of the scheduled appointment time. The price for a missed appointment is \$20. Insurance companies do NOT pay for a missed appointment charge. Appointment cancellations must be made at least 4 hours before the scheduled appointment time, and when possible, 24 hours in advance. If you have missed three (3) consecutive appointments and have not contacted the office this would unfortunately prompt a **DISMISSAL** from our practice.

## **CO-PAYS AND RETURNED CHECK FEE:**

Some insurance companies require a co-pay fee. The fee is due **AT TIME OF SERVICE** or your appointment will be rescheduled. If a check is returned for insufficient funds an additional fee of \$50 will be charged.

## **PAYMENT POLICIES:**

**As of January 1, 2010 ALL MOTOR VEHICLE ACCIDENTS** will be payment at time of service including all self pay individuals. We do not third party bill.

## **AUTHORIZED SIGNATURE:**

I authorize that I have read this document and completed the requested information to the best of my ability.

\_\_\_\_\_  
**PATIENT NAME** (Please PRINT full name)      **DATE**      **PATIENT SIGNATURE**

Sign and date below for a patient that is a minor:

\_\_\_\_\_  
**PARENT/GUARDIAN NAME** (PRINT Name)      **DATE**      **PARENT SIGNATURE**

44 Birch Street, Nutfield Professional Park, Suite 305, Derry, NH 03038  
168 Kinsley Street Medical Arts Building, Suite 10, Nashua, NH 03060  
Phone 1-800-591-1815

Fax 603-425-1109 Derry

Fax: 603-886-1815 Nashua