The Centers for Advanced Orthopaedics

Patient Financial Agreement and Assignment of Benefits

I agree to be responsible for the payment of all fees ("Fees") related to the services provided to me by Centers for Advanced Orthopaedics, LLC ("CAO") and its physicians and clinical providers (the "Services"). I understand that CAO will bill my insurance carrier, as a courtesy to me, based on the information I provide to CAO. Any portion of the Fees that are not paid by my insurance carrier to CAO shall remain my sole responsibility. Payment for the Services rendered to me by CAO is due and payable in full on the date of service.

IF I HAVE HEALTH INSURANCE:

I hereby authorize CAO to submit claims to my insurance carrier for payment of all Fees associated with the Services and agree to cooperate with CAO in providing all necessary information and authorization for submission of such claims. I agree to pay to CAO, on the date of service, all co-pays, co-insurance, and deductibles due under my insurance plan and all charges for Services that are not covered under my insurance plan.

I understand that CAO will invoice me for any balance of Fees remaining after my insurance plan has processed the claim, and I agree to pay any such balance to CAO within thirty (30) days of the date of the invoice.

I understand that it may not always be possible for CAO to determine the amount of the Fees that will be covered by my insurance plan and the amounts that I will be responsible for paying during my visit. In such instances, CAO will expect me to pay an estimated amount of my share of the Fees. CAO will promptly refund any excess amounts collected.

In the event my insurance carrier is expected to have little or no financial responsibility for the cost of a visit (such as at the beginning of the plan year when my out-of-pocket limits reset), CAO may collect up to $250 from me for a medical appointment and up to $150 for a physical therapy or hand therapy appointment at the time of the visit.

IF I DON'T HAVE HEALTH INSURANCE:

If I do not have health insurance coverage for the Services or if I direct CAO not to bill my insurance for the Services (i.e., self-pay), I agree to be responsible for payment of all Fees to CAO for the Services in accordance with any good faith estimates provided to me. I understand that CAO requires at least 3 days to provide a good faith estimate of charges.

As a self-pay patient, I agree to pay a minimum of $250 for a medical visit and $150 for an initial physical therapy or hand therapy visit and $100 for a follow up visit before I am seen in the clinic. I also agree to pay the balance of the Fees at the conclusion of my visit based on the total good faith estimate and/or the total cost of the Services rendered to me that day.

Additional Fees:

I hereby authorize the following additional fees to be charged to me by CAO under the following circumstances:

- No-Show/Cancellation Fee: I agree to pay a no-show fee based on the type of appointment as set forth in the schedule below:

VISIT TYPE	NOTICE REQUIREMENT	FEE
Office Visit	24 hours prior to appointment	$50
Therapy Visit	24 hours prior to appointment	$35
Extended Office Visit*	24 hours prior to appointment	$75
Surgical Procedure	3 business days before surgery date	$300
Functional Capacity Evaluation	3 business days before scheduled date	$100

*Patient will be informed, at the time of scheduling, when a visit is an "Extended Office Visit".

- Returned Check Fee: I agree to be charged a fee of $25.00 if a check written by me is returned to CAO due to insufficient funds. After any such return, I agree to pay the remaining balance due by cash, credit card or money order.
- Collection Fees (this applies to Maryland and Virginia patients only): I agree to pay for all fees incurred by CAO in engaging a debt collector to collect any outstanding balance of Fees that remains unpaid for at least ninety (90) days following the date of the applicable invoice.
- Fees for Copies of Records: I acknowledge that I may obtain electronic copies of most of my patient records on CAO's Patient Portal at no cost to me. If I request paper copies of my patient records or electronic copies of records not otherwise available on the Portal, I agree to pay fees for such copies that do not exceed the maximum amount allowed under applicable law.

Assignment of Benefits

I irrevocably assign to CAO all of my rights and benefits and any other interests that I have in my insurance plan in connection with the Services. I understand that this document is a direct assignment of my rights and benefits under such plan. I instruct my insurance plan to pay CAO directly for the professional or medical expense benefits payable to me, and, if direct payment is not permitted, to mail a check in my name to CAO, which I hereby irrevocably authorize CAO, as my special power of attorney, to endorse over to it in payment of the Fees.

Workers Compensation / Auto Accident Claims

I agree to complete all forms necessary for CAO to file workers compensation or auto accident/ PIP insurance claims on my behalf, and I agree to provide CAO with my personal health insurance information to be used in the event that such other coverage is denied.

Referrals

If I have an insurance plan (such as an HMO) that requires a referral for the Services, I understand that I must obtain the referral prior to my scheduled appointment. CAO will not obtain the referral on my behalf.

Agreement to Charge

I hereby authorize CAO to charge any credit or debit card I have given to CAO to pay for all co-pays, co-insurance and deductibles due for the Services and all unpaid Fees that are my responsibility hereunder, if I fail to pay any balance of Fees when due.

By signing below, I agree to all of the terms of this Patient Financial Agreement and Assignment of Benefits.

X _____

Patient / Agent / Guardian Signature Date: