PATIENT INSTRUCTIONS: REGISTRATION FORMS

Orthopaedics, Pain Management, & Imaging

Step 1: Before you come in, please:

Decide how you want to handle the fees:

- **Option 1. Use your insurance.**
  - OSS will check your benefits BEFORE your visit.
  - Even if your health insurance is in network, you may be required to handle a deposit of $120 and/or copay.
- **Option 2. Be self-pay** (and use no insurance). To find out the price for service, go to ossburbank.com or ask OSS.

Fill out registration forms.

- Fill out all forms in this packet and email to specific office (if listed below).
- Read consents (e.g., no pets allowed)

Directions, educational videos, meet your provider, learn how we work?

Go to: **ossburbank.com**

Already have an X-Ray, CT Scan or MRI?
Please bring image(s) on a CD and report(s).

Need to **cancel?** Give us at least 24 hours notice.

ORTHOPAEDICS, PAIN MANAGEMENT, & IMAGING

Burbank (Main Office)
Pacific Ave & Hollywood Way

3413 W Pacific Ave,
#100
Burbank, CA 91505
T: (818) 841-3936
F: (818) 841-5974
info@ossburbank.com

- Dr. Yuri Falkinstein
- Dr. Chrystina Jeter
- Dr. Mark Mikhael
- Dr. Ray Raven, III
- Dr. Shahan Yacoubian
- Dr. Stephan Yacoubian
- Orthopaedic Physician Assistants
- MRI, CT Scan, Bone Density Scan (DEXA)

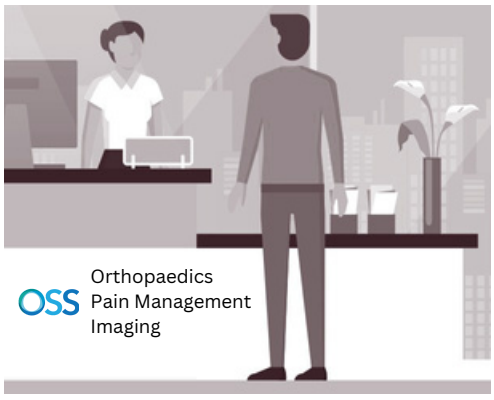
Re-opens Monday, April 17th, 2023

Burbank
W Alameda Ave

2625 W Alameda Ave
#116
Burbank, CA 91505
T: (818) 506-0999
F: (818) 762-1740

- Dr. Richard Feldman
- Dr. Jeffrey Korchek

Step 2: When you arrive, be ready with:



Arrival Time For All Appointments

Forms done? 10 minutes before
Not done? 20 minutes

Completed registration or safety forms. If you emailed, let us know

A list of current medications

Dress in a way that will allow us to best evaluate your injury

Images of your injury or area of pain (if you have)

Photo ID, health insurance card, and credit card

MasterCard VISA DISCOVER AMERICAN EXPRESS

OSS
ossburbank.com

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

ORTHOPAEDIC SURGERY SPECIALISTS & AFFILIATED ASSOCIATES
Print or Stamp Name of Physician, Medical Group, or Associate Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

By: _____
(if Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(01-16)

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PATIENT PERSONAL FORM

Kindly use Black Ink

GENERAL

Patient Name (Last Name, First Name, M.I.) | Today's Date (MM/DD/YY)

Social Security # | Driver's License / State Issued | Gender: Male ☐ Female ☐ | Date of Birth (MM/DD/YY)

Email Address (Tip! Email will get you access to our OSS Patient Portal) | Name of Spouse / Partner

Home Address (Please include Street Number, Street Name, City, State, Zip Code

Primary Telephone (1st # to reach you) Cell ☐ Home ☐ Work ☐ | Secondary Telephone Cell ☐ Home ☐ Work ☐

Emergency Contact, Your Relationship, & Primary Telephone

EMPLOYMENT

Employer & Job Title

Is this a work related injury? Yes ☐ No ☐ | Work Comp Insurance Carrier & Claim #

If yes, has your employer been notified? Yes ☐ No ☐ | Claim Adjuster & Telephone

PHARMACY (Tip! We can refill your Rx faster if you provide us this information)

Pharmacy Name, Address & Telephone

MEDICAL REFERRALS

Who referred you to our practice?

☐ Doctor ☐ Relative ☐ Friend ☐ Internet ☐ Hosptial ☐ Insurance Company Name

LEGAL

Is there a legal case or lawsuit involved with this injury? ☐ Yes ☐ No | Attorney or Liability Representative Name and Telephone

Is an attorney, liability carrier, or auto insusrance invovled in payment? ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

SECONDARY INSURANCE

Insurance Company Name	I.D. / Policy Number	Group Number
Insured Name	Insured Social Security #	Insured Date of Birth (MM/DD/YY)
Subscriber of the Health Insurance & Relationship	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsbility for ALL services provided.

X

Signature of Patient or Responsible Party *Date*

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

GENERAL

Name *Last Name* *First Name* *M.I.*				Today's Date (MM/DD/YYYY) / /
Gender ☐ Male ☐ Female	Height	Weight	Age	Which is your dominant hand? ☐ Left ☐ Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today? Which side? (if applicable) ☐ Left ☐ Right

What is the goal of your appointment today?

☐ Pain Management ☐ Better Function ☐ Better Appearance ☐ Return to Work ☐ Return to Play ☐ Other: _____

How did the problem develop?

When did the problem start: ☐ Over Time (Duration:_____) ☐ Injury (Date of Injury: _____)

Is this work related? ☐ Yes ☐ No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakenss? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:_____ ☐ Other: _____

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable; Don't use a walking device

Describe how you use stairs: ☐ Place one foot per step ☐ Place both feet on step before proceeding to next ☐ Not Applicable; Don't use stairs

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

MEDICAL HISTORY: LIST ALL

Medical problems:

Medications:

Supplements:

Surgeries:

Drug allergies (include reaction):

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed **Name:**

Hobbies / Interests: **Occupation:**

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point) ☐ 3 or 4 drinks (1 point) ☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points) ☐ 10 or more drinks (4 points)

If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point) ☐ Less than monthly (1 point) ☐ Monthly (2 points)

☐ WeekIt (3 points) ☐ Daily or almost daily (4 points)

Do you use tobacco products? ☐ No ☐ Yes **If yes, how many packs per day?**

Do you use recreational drugs? ☐ No ☐ Yes **Describe:**

IF YOU ARE 65 OR OLDER

Do you have an advance care plan or surrogate decision maker?

Have you fallen in the last 12 months? ☐ No ☐ Yes **If "Yes": How many times?** **Were you injured?**

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ **Signature**_____ **Date**____/____/____

USE BLACK INK

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MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

HEALTH REVIEW (Do you have any of the following?)

GENERAL			***GASTROINTESTINAL***		
Have you been in good general health most of your life	☐ No	☐ Yes	Vomiting blood or food	☐ No	☐ Yes
Any allergies, including medication	☐ No	☐ Yes	Gallbladder disease	☐ No	☐ Yes
Any recent weight gain	☐ No	☐ Yes	Liver trouble	☐ No	☐ Yes
SKIN			Hepatitis	☐ No	☐ Yes
Skin Disease	☐ No	☐ Yes	Painful bowel movements	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Black stools	☐ No	☐ Yes
Hives, eczema or rash	☐ No	☐ Yes	Hemorrhoids or piles	☐ No	☐ Yes
Frequent infections or boils	☐ No	☐ Yes	Recent changes in bowel habits	☐ No	☐ Yes
Abnormal pigmentation	☐ No	☐ Yes	Heartburn or indigestion	☐ No	☐ Yes
HEAD, EYES, EARS, NOSE, THROAT			***GENITOURINARY***		
Eye diseases or injury	☐ No	☐ Yes	Loss of urine	☐ No	☐ Yes
Wear glasses	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes
Double vision	☐ No	☐ Yes	Night time urinating	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Kidney trouble / Kidney stones	☐ No	☐ Yes
Itching eyes or nose	☐ No	☐ Yes	***LOCOMOTOR - MUSCULOSKELETAL***		
Sneezing or runny nose	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes	Varicose veins	☐ No	☐ Yes
Chronic sinus trouble	☐ No	☐ Yes	Weakness of muscles or joints	☐ No	☐ Yes
Ear disease	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes
Impaired hearing	☐ No	☐ Yes	Pain in calves or buttocks on walking, relieved by rest	☐ No	☐ Yes
Dizziness or transient episodes of unconsciousness	☐ No	☐ Yes	***NEURO - PSYCHIATRIC***		
RESPIRATORY			Ever had psychiatric care	☐ No	☐ Yes
URI (cold) now	☐ No	☐ Yes	Ever been advised to see a psychiatrist	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes
Chronic of frequent cough	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes	Paralysis	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	***ENDOCRINE***		
CARDIOVASCULAR			Diabetes	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Shortness of breath with walking or lying down	☐ No	☐ Yes	Hormone therapy	☐ No	☐ Yes
Heart trouble or heart attacks	☐ No	☐ Yes	Any change in hat or glove size	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Any change in hair growth	☐ No	☐ Yes
Swelling of hands, feet or ankles	☐ No	☐ Yes	Become colder than before or skin become dryer	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	***HEMATOLOGICAL***		
NECK			Slow to heal after cuts	☐ No	☐ Yes
Stiffness	☐ No	☐ Yes	Blood disease	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
			History of blood clots	☐ No	☐ Yes
			Bleeding problems	☐ No	☐ Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Suicide	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Mental illness	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Bleeding tendency	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Gout or other arthritis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hereditary defects	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print)_____ **Signature**_____ **Date**____/____/____

HIPAA PRIVACY PREFERENCES

Please select the level of privacy you would like Orthopaedic Surgery Specialists (OSS) to observe concerning your information (appointment information, test results, procedure results, etc.)

☐ OSS may only discuss my information with me, directly.

If we are not able to reach you directly, may we provide you with your information via messages?

☐ OSS may leave voice messages containing my information at the following phone number(s):

_____ (home) _____ (cell) _____ (work) _____ (other)

☐ OSS may send unencrypted emails from the physician and his staff to the following e-mail address:

_____
(e-mail address)

Is there anybody else that you would like to allow us to speak to about your information if they inquire about you? This should be anyone (family member, friend, caretaker, etc.) that might ever come into an appointment with you, help you with your forms, call to make or check on an appointment for you, or pick anything up for you from our office. **If someone does come to us on your behalf but their name is not listed below, we will not be able to share anything with them regarding any of your information.**

☐ OSS may share my information with the following individuals:

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

Those listed above **must answer the following security question before any information is shared:

What is the patient's birthday? _____

Under the requirements of HIPAA we are not allowed to give information to anyone other than the patient without the patient's written consent. Signing this form will only give consent to release appointment information, test results, and procedure results to the designated person(s) above. This consent form will not allow the doctor to release any other information to this person. You may revoke this consent in writing except where we have already made disclosures on your prior consent.

_____ (print patient's name) _____ (sign patient's name) _____ (date)

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OUR POLICY

Kindly read and sign our Office Policy and the financial program that you will use. If you have any questions, please discuss with our staff before you see the provider. ***Thank you.***

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my insurance carrier, including Medicare to pay directly to my physician, Orthopaedic Surgery Specialists & Affiliated Associate, for services rendered for me. I hereby authorize my physician to release information from my medical records necessary to bill my insurance carrier for these services. A photocopy of my signature on this form is to be considered as valid as the original.

Patient or Insured Name (print): _____

Signature: _____ Date: _____

NARCOTIC (PAIN) PRESCRIPTION

The doctors prescribe Narcotic Medications only in cases of acute injury and after surgery for a period of no more than 4 weeks. If you require long term pain control, you will be referred to you primary care physician or to a pain management specialist. ***Our office requires 48 hours to process narcotic prescription refills***. Please contact us or your pharmacy so you will not run out of medication while waiting for your prescription to be processed. **Prescriptions will only be refilled between** 8:30 AM - 4:30 PM, Monday through Friday.

Signature: _____ Date: _____

DISABILITY BENEFITS

If you have an acute orthopaedic injury or are recovering from surgery, the doctors and staff at OSS will coordinate disability benefits for you.

- Typically, our office will coordinate this benefit for you up to 3 months. **However, please understand that your orthopaedic doctor will make the decision based on the type of injury you have.**
- Moreover, if you are a being treated for chronic pain by Dr. Falkinstein, then OSS can coordinate the disability benefit for you up to 6 (six) months.

Please understand the doctors and staff at OSS are unable to coordinate the disability benefit for you beyond this stated policy. We of course do encourage you to speak with your primary care doctor since s/he is the designated doctor who routinely cares for your health over the long term.

Signature: _____ Date: _____

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OUR POLICY

MISSED APPOINTMENTS / CANCELLATIONS

We understand that emergencies arise, however, appointments are pre-arranged and it is the patient responsibility to keep the appointment or cancel with a minimum of ***48 hours*** notice.

Signature: _____ Date: _____

FINANCIAL PROGRAM OVERVIEW

Orthopaedic Surgery Specialists Specialists (OSS) accepts patients many Preferred Provider Organization (PPO) health insurance plans, Medicare, Worker's Compensation, patients who are self pay (not using insurance) and/or out of network. To receive treatment, OSS will first **verify** your insurance benefits **before** your scheduled appointment with us. We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

Most patients will use their health insurance coverage if OSS has contracted services with the specific plan. Please read and sign the **In Network Program** which is included in this packet.

If you know that your health insurance is not in our network or if you are self pay (not using health insurance *and* you will pay for all services at the time of your appointment), then you will be asked to read and sign the specific financial program form in the office. (Tip! You do not need to sign the In Network Program document) If you have any questions, please call us at 818.841.3936.

NOTICE OF PRIVACY PRACTICES: PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives access to our Notice before signing this acknowledgment. If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to melissap@ossburbank.com or a letter to:

Privacy Officer/Melissa Pereda
OSS
3413 W. Pacific Avenue, #100
Burbank, CA 91505

By signing this form, you are only acknowledging that you have been provided access to our Notice.

Patient or Authorized Representative Name (print): _____

Signature: _____ Date: _____

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IN NETWORK PROGRAM

Orthopaedic Surgery Specialists (OSS) offers an In Network Program that allows you or a minor to receive treatment for an orthopaedic injury by using your health insurance that is in our network (OSS has a contract with the plan).

FINANCIAL CONTRACT

As an "**in network" health insurance** patient, you make the commitment to:

- Show us your valid health (medical) insurance card and photo ID at each visit.
- Notify us if there have been any changes to your health insurance, address or phone number.
- Pay your insurance co-pay **prior** to services rendered.
- Provide a deposit (of up to $120) if you have **not** met your deductible, regardless of health insurance policy and/or co-pay. Once we have billed your health insurance and have received a response from your health insurance (typically written in the Explanation of Benefits (EOB)), OSS will refund the remaining deposit (overpayment) *or* bill you for any services that were above the amount we initially collected.
- For a scheduled surgery, provide a deposit for your portion of our fees. Once we have received a response to our bill from your health insurance (typically written in the EOB), OSS will refund the remaining deposit (overpayment) to you *or* bill you for the remaining balance.
- Provide payment for the patient who is under the age of 18.
- Respond to **any** billing or health claim inquiries that you have either received from Orthopaedic Surgery Specialists or from your insurance company. Failure to respond to either party in a timely fashion could lead to additional charges that you will need to pay.
- Send payment once you receive your bill from OSS.
- Understand that **not** all health plans are the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will still be responsible to pay the OSS fee. If you are concerned about this possibility, please read your insurance booklet or the contract
- If you have a broken bone or fracture, then please understand that many times, health insurance companies will use the terms "office surgery" or "office procedure" on your Explanation of Benefits (EOB) for the fracture / broken bone or injection claim. When you are charged a "global fee" for surgery or office care of a fracture (broken bone), laceration repair, excision of an ingrown toenail, etc., the global fee includes the service on the day it is performed and the routine follow-up care for that injury. The global period ranges from 10-90 days depending on the procedure.
    - The following **are not included** in the "global fee" and will most likely result in an additional charge(s):
        - X-rays and supplies for casting, splints, braces, etc.
        - Services rendered if complication arises.
        - New or unrelated orthopaedic injury.

I agree to follow the In Network Program Financial Contract.

Patient or Insured Name (print): _____

Signature: _____ Date: _____