

**SARASOTA ORTHOPEDIC ASSOCIATES  
FINANCIAL RESPONSIBILITY AGREEMENT**

IN CONSIDERATION OF THE PROFESSIONAL SERVICES, WHICH I, OR MY DEPENDENTS, RECEIVE AT SARASOTA ORTHOPEDIC ASSOCIATES, I AGREE TO BE FULLY RESPONSIBLE FOR THE CHARGES. I WILL MAKE PAYMENT UPON RECEIPT OF SERVICES OR UPON RECEIPT OF A BILLING INVOICE, DEPENDING UPON THE BILLING ARRANGEMENTS ESTABLISHED FOR ME BY SARASOTA ORTHOPEDIC ASSOCIATES. I UNDERSTAND THAT I MAY BE REQUIRED TO MAKE A PAYMENT AT THE TIME (S) OF MY VISIT (S) FOR THE CHARGES FOR THE VISIT (S), APPLICABLE CO-PAYMENT AMOUNTS, DEDUCTIBLES AND / OR PAST DUE BALANCES.

WHEN I USE MEDICAL INSURANCE AS A SOURCE OF PAYMENT FOR THE CHARGES INCURRED BY ME, OR MY DEPENDENTS, I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES. AFTER MY CARRIER/PLAN MAKES PAYMENT FOR ITS PORTION OF THE COVERED CHARGES, I REMAIN RESPONSIBLE FOR ANY BALANCES WHICH ARE DUE FOR THOSE COVERED CHARGES. I WILL ALSO BE RESPONSIBLE FOR ANY CHARGES THAT MY CARRIER DOES NOT AUTHORIZE PRIOR TO, OR DURING, THE VISIT.

IF I AM INJURED AND HAVE A CLAIM AGAINST A THIRD PARTY, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR THE SERVICES AT THE TIME THE SERVICES ARE RENDERED AND NOT AT THE TIME MY CLAIM IS SETTLED. IF SARASOTA ORTHOPEDIC ASSOCIATES MAKES DEFERRED PAYMENT ARRANGEMENTS, I AUTHORIZE MY ATTORNEY TO PROVIDE TO SARASOTA ORTHOPEDIC ASSOCIATES ANY INFORMATION REGARDING MY INJURY CLAIM.

IN THE EVENT I OWE A BALANCE ON MY ACCOUNT AT SARASOTA ORTHOPEDIC ASSOCIATES AND I FAIL TO MAKE TIMELY PAYMENTS, I UNDERSTAND THAT SARASOTA ORTHOPEDIC ASSOCIATES MAY REFER MY ACCOUNT TO A COLLECTION AGENCY OR AN ATTORNEY FOR FURTHER ACTION. IF IT IS NECESSARY TO REFER MY ACCOUNT FOR COLLECTION, I AGREE TO PAY THE COLLECTION AGENCY FEES AND/OR ATTORNEY'S FEES AND ANY COST INCURRED IN THE COLLECTION OF MY ACCOUNT.

**ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION**

IN CONSIDERATION OF THE TREATMENT RENDERED TO ME OR MY DEPENDENTS, I ASSIGN TO SARASOTA ORTHOPEDIC ASSOCIATES ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I, OR MY DEPENDENTS, ARE ENTITLED FOR SUCH TREATMENT. MEDICAL/SURGICAL BENEFITS INCLUDE, BUT ARE NOT LIMITED TO, MEDICARE, PRIVATE HEALTH INSURANCE, AUTOMOBILE, LIABILITY AND WORKER'S COMPENSATION INSURANCE AND MEDICAID. THIS ASSIGNMENT SHALL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE GIVEN THE SAME EFFECT AS THE ORIGINAL.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS**

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, THE HEALTH CARE FINANCING ADMINISTRATION, ITS INTERMEDIARIES OR OTHER MEDICARE AFFILIATED CARRIERS, ANY INFORMATION NEEDED FOR THIS CLAIM OR A CLAIM FOR RELATED SERVICES. I AUTHORIZE SARASOTA ORTHOPEDIC ASSOCIATES TO SUBMIT CLAIMS TO MEDICARE FOR SERVICES FURNISHED TO ME. I REQUEST THAT MEDICARE MAKE PAYMENT OF AUTHORIZED BENEFITS ON MY BEHALF AND I ASSIGN THESE BENEFITS, PAYABLE FOR SERVICES FURNISHED TO ME, TO SARASOTA ORTHOPEDIC ASSOCIATES OR THE ORGANIZATION FURNISHING THE SERVICES.

I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSIBILITY AGREEMENT AND AGREE TO THE TERMS. I ACKNOWLEDGE RECEIVING A COPY OF THE FINANCIAL RESPONSIBILITY AGREEMENT.

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN/RESPONSIBLE PARTY

\_\_\_\_\_  
RELATION TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
GUARANTOR

\_\_\_\_\_  
RELATION TO PATIENT

\_\_\_\_\_  
DATE