Hampton Roads Orthopaedics & Sports Medicine
Payment Policy

PAYMENT POLICY AND INSURANCE ASSIGNMENT RELEASE: The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and Hampton Roads Orthopaedics & Sports Medicine or its affiliated service groups. I authorize the filing of claims (electronically and/ or hard copy) against any insurance in force and other third party payer including Medicare, Medicaid, or Workers' Compensation carriers, and further assign direct payments to Hampton Roads Orthopaedics & Sports Medicine. The undersigned understands that he/she is responsible for payment of any charge not covered by this agreement, and that monies recovered in excess of the patients' indebtedness will be refunded. In the event of any default on any payment due Hampton Roads Orthopaedics & Sports Medicine and its affiliated service groups, I agree to pay all costs including 33 1/3% collections and attorney fees. I also authorized Hampton Roads Orthopaedics & Sports Medicine or agents to speak to me regarding my balance. I authorize the release of any medical information to process claims for services rendered I understand there is no guarantee of treatment outcomes.

If I do not have active insurance or a valid referral (if applicable) today, I understand that I will have to pay for today's visit. I understand that if my insurance company requires a referral, I have to inform Hampton Roads Orthopaedics & Sports Medicine. I also have to get a referral for this date of service. The estimated cost of services for today's' visit is $363. I understand that this payment is non-refundable. **By signing this form, I agree that I will be paying for today's' visit if my insurance company does not pay**.

If I have Medicare, Medicaid, or Tricare, I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare/Medicaid/Tricare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

OWNERSHIP: I have been made aware that the surgeons of Hampton Roads Orthopaedics & Sports Medicine have ownership in HROSM Physical Therapy, HROSM Interventional Spine & Sports Institute, HROSM of Williamsburg, HROSM Foot and Ankle Center, Open Multi-Positional MRI Center, and Hampton Roads Urgent Care, and the Mary Immaculate Ambulatory Surgical Center.

APPOINTMENT CANCELLATION/NO-SHOW POLICY: In order to provide the best care to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so will result in a missing appointment fee of $50.00.

Patient/Parent/Guardian Name:_____

Patient/Parent/Guardian Signature:_____ 

Date:_____