

**UNION COUNTY ORTHOPAEDIC GROUP PAYMENT
POLICY**

I understand that charges may not be covered by my insurance company, as well as applicable copayments, coinsurance and deductibles which are my responsibility.

I authorize my benefits to be paid directly to Union County Orthopaedic Group to release pertinent medical information to my insurance company when requested or to facilitate the payment of a claim.

I understand and agree that if the insurance carrier issues payment directly to me for services rendered, I will immediately forward the check(s) along with the Explanation of Benefits (EOB) to Union County Orthopaedic.

Failure to forward insurance check (s) to the proper provider or facility may result in legal action.

I understand failure to cancel three office visits will require a \$100 deposit prior to all future visits.

DATE

SIGNATURE

PRINTED NAME