Contract of Financial Responsibility

In agreeing to be responsible for your medical care, Charlotte Orthopaedic Clinic, P.A. requires that you be responsible for your *financial obligations to us.*

Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf

1. I agree that I will pay for all services provided to me by Charlotte Orthopaedic Clinic at the time of service, unless my services are covered by a contracted insurance.

2. I understand that my insurance company or health plan may require me to pay co-payments, co-insurance or deductibles. I agree to pay these in full at the time of service.

3. I understand that if, upon 60 days after billing and/or insurance filing, my contracted insurance has not paid, I will be required to contact them to find out why the claim has not been paid.

4. I understand that if, 60 days after billing, I fail to pay any balance due on my account (unless this balance is still out to a contracted insurance), further action may be taken on my account, unless other previous arrangements have been made and approved by Charlotte Orthopaedic Clinic, P.A.

5. If my account is sent to collections, I am responsible for all amounts due *plus* all costs of collection, including:

- A handling charge of $50.00 may be added to my account if it must be sent to collections;
- All collection expenses charged by the collection agency;
- Court costs;
- Reasonable attorneys' fees; and
- Any discounts I may have received on my account will be reversed.

6. I also understand that at the discretion of Charlotte Orthopaedic Clinic, P.A., I may be taken to small claims court for full reimbursement of all fees and balances.

7. If further action must be taken on my account, Charlotte Orthopaedic Clinic, P.A. may require me to permanently seek further care elsewhere, in accordance with guidelines set forth by the **Florida State Board of Medical Examiners.**

Thank you very much.

SIGNATURE (Patient or Parent of Minor): ______________________________

PLEASE PRINT NAME: ______________________________ DOB ____________

TODAY'S DATE: ______/______/______

Revised 09/12/06

CHARLOTTE ORTHOPAEDIC CLINIC, P.A.