Patient Name: _____ Date _____

SELF PAY PATIENTS

It is the policy of Arizona Bone and Joint Specialists, A Division of OrthoArizona to require an initial $200.00 prepayment for orthopaedic concerns.

Regardless of your balance due, we will require subsequent payments of at least $100.00 per visit, appointment(s). Any over-payment will be issued as a refund at the completion of your treatment.

We accept Visa, MasterCard, Discover or personal check.

If you have questions or concerns, please contact our billing department at: 602-493-9361 option 3.

ACKNOWLEDGMENT OF FINANCIAL POLICY

Your signature below signifies that you have read and understand and agree to accept Arizona Bone and Joint Specialists, A Division of OrthoArizona Financial Policy and acknowledge your responsibility regarding all fees related to your care.

Further, I authorize payment directly to Arizona Bone and Joint Specialists, A Division of OrthoArizona, of any insurance policy benefits, and I hereby assign all such policy benefits to Arizona Bone and Joint Specialists, A Division of OrthoArizona. I authorize Arizona Bone and Joint Specialists, A Division of OrthoArizona to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies. This authorization is valid for every visit to Arizona Bone and Joint Specialists, A Division of OrthoArizona until written notice revoking this authorization is received.

_____ _____

Patient/Parent-Guardian Signature Date

If Parent-Guardian's signature appears above, please describe Parent-Guardian's relationship

to the patient:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Arizona Bone and Joint Specialists, A Division of OrthoArizona, Notice of Privacy Practices. This Notice describes how Arizona Bone and Joint Specialists may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and my rights regarding my protected health information.

Please indicate any persons authorized to discuss your protected health information with our staff. Include the name and relationship to yourself, and a start date an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date

_____ _____

Patient/Parent-guardian Signature Date

If Parent-Guardian's signature appears above, please describe Parent-Guardian's relationship

to the patient:_____