# Connecticut Center for Orthopedic Surgery, LLC Payment Policy

We wish to help you receive the maximum allowable benefits from your health benefits. In order to do this, we need your cooperation and understanding with our payment policy.

In order to obtain and maintain proper insurance information, you may need to present your insurance card at each visit. In some circumstances, we may accept assignment of insurance benefits. Accepting benefits still required you to pay all applicable co-payments, coinsurance, and deductible amounts applicable to your insurance plan. Payment is due at the time services are rendered. We accept cash, check and credit cards.

We realize that temporary financial problems may affect the timely payment of your account. If such problems arise, call our billing company, IPMS, 860-282-4127 for help in managing your account. Delinquent accounts are subject to collection activity for which you will incur additional charges.

**Authorization and release**

By my signature below, I hereby authorize Connecticut Center for Orthopedic Surgery, LLC to release any and all medical information relating to my treatment necessary for my insurance carrier or governmental agency to process my medical claim for payment. I understand that I am responsible for any and all charges not covered by my insurance and I understand that if my account becomes delinquent, I am responsible to pay all costs of collecting my outstanding balance including court costs and attorney's fees, to the extent allowed by law. I further acknowledge that should I fail to pay promptly, my outstanding debts may be turned over to a collection agency. If my account becomes delinquent and is sent to a collections agency, and if I wish to return to the practice, I will be expected to pay the previous balance in full, as well as all changes due to the collection agency. This can amount to previous charges plus an additional 25% which CCOS, LLC must pay to the collections agency.

**Assignment of benefits**

By my signature below, I request that Medicare and/or my insurance carrier make any authorized benefit payments otherwise payable to me directly to Connecticut Center for Orthopedic Surgery, LLC for any services provided by James T. Mazzara, MD and/or his assistants.
I agree that I will assume full responsibility for all charges submitted for Connecticut Center for Orthopedic Surgery, LLC, if my insurance denies coverage because I, or my primary care physician, did not provide a valid referral for the services provided **or** because I did not provide necessary insurance or clinical information required by Connecticut Center for Orthopedic Surgery, LLC or my insurance carrier.

Signature Relationship Date

**Worker's compensation**

By my signature below, I acknowledge that I have been informed that Connecticut Center for Orthopedic Surgery, LLC will release any and all records relating to my injury to my employer and worker's compensation carrier as required by law.

I also understand that and agree if my worker's compensation claim is rejected by my employer and/or carrier, I am fully responsible for all charges for services provided by Connecticut Center for Orthopedic Surgery, LLC. I will provide my private health insurance information and allow Connecticut Center for Orthopedic Surgery, LLC to submit those charges to my private insurance carrier in the event this occurs.

Signature Relationship Date

________________I refuse to provide my private health insurance information and, if worker's compensation rejects my compensation claim for any reason, I assume full responsibility for all charges submitted by Connecticut Center for Orthopedic Surgery, LLC.

**Self-pay Patients**

Patients without insurance, those paying for their own services, or insured patients who have insurance in which Dr. Mazzara and his employees are considered non-participating providers may be expected to pay for services at the time of their visit *prior to* seeing the doctor or physician assistant. By signing below, I acknowledge that this prepayment may not necessarily be payment in full but may be partial payment for services rendered. I understand that I am responsible for any and all charges not covered by insurance and I understand that if my account becomes delinquent, I am responsible to pay all costs of collecting my outstanding balance including court costs and attorney's fees, to the extent allowed by law. I further acknowledge that should I fail to pay promptly, my outstanding debts may be turned over to a collection agency.

Signature Relationship Date

**For Minors:** If the patient is a minor, I hereby authorize Dr. James T. Mazzara, MD and/or his associates to perform diagnostic and therapeutic measures on ________________________________________________________________________________

Signature Relationship Date