AOSM

Orthopedic Surgery

Christine Kohler Ekstrand, M.D.
Delray Medical Staff
West Boca Medical Center Staff

5258 Linton Blvd.
Suite 304
Delray Beach, FL 33484
(954) 251-6051 Fax (954) 653-7207
EkstrandOrtho@gmail.com

Dear Patient:

We look forward to providing you with the best medical care possible. Please fill out the attached paperwork thoroughly, so that the doctor will have all the necessary paperwork to treat you. We would like to take this opportunity to acquaint you with our business office policies;

- **Co-payments, deductibles, and co-insurance are collected at the time of service**.
- **We will bill you any patient balance after we receive the explanation of benefits from your insurance company.**
- **We require a full 24 hours' notice for appointment cancellation. You may be billed for cancellations made without notice.**
- **Services are not rendered on a "lien" basis (deferral of payment pending the settlement of legal cases).**
- **Services are not rendered on a third-party basis, meaning that we cannot bill another party's auto insurance medical pay.**
- **We accept all forms of payments. All credit card transactions will access an additional fee of 3.49% plus .30¢ per transaction.**

We will bill your insurance for plans which we are participating providers. It is imperative that you inform us of any changes which you make in your insurance coverage, such as switching to a different insurance company, policy number or a different plan. Please inform us of coverage changes prior to scheduling your appointment. Failure to provide us with this information may result in your becoming personally liable for the charges. I understand and agree to the above financial policies and procedures.

Print Name: ______________________________ Signature: ______________________________

Date: ______________

Authorization to Pay Physician/ Assignment of Benefits

I hereby authorize ________________________ insurance company to make payment and mail it directly to Advanced Orthopedic Surgery and Sports Medicine at the address indicated for the medical and surgical expense benefits and the medical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I authorize the release of any medical information necessary to process this claim. This payment will not exceed my indebtedness to the above-mentioned assignee(s) and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

Print Name: ______________________________ Signature: ______________________________

Date: ______________

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As you know, if you have ever checked into a hotel or rented a car, the first thing you are required to do is to provide your credit card information which will be used to pay your bill.

You will be required to provide your credit card information at the time of your check your appointment. The information will be held securely until your insurance has paid their portion and notified our office of your remaining deductible amount.

At that time, any remaining unpaid balance is owed to us by you and your credit card will be charged for that remaining balance. A copy of the charge will be mailed to you.

This service will not compromise your ability to dispute a charge or question your insurance company's determination of payment. In addition, all copays are due at the time of service and will continue to be collected at the visit.

If you have any questions, please call (954) 251-6051.

Authorization to charge credit card:

Patient Name: ______________________________ DOB: ____________

I have read the above policy and authorize Advanced Orthopedic Surgery and Sports Medicine to keep my signature on file and to charge my credit card for the outstanding balance to my account (deductibles, co-pays and non-covered services) NOT paid by my insurance company.

Credit Card Type: ☐ VISA ☐ Master Card ☐ American Express ☐ Other:____________

Credit Card #: ______________________________ 3 Digit Security Code: ______

Name on Card: ______________________________ Expiration Date: __________

Billing Zip Code: ______________

Signature: ______________________________ Date: ____________