Name: _____
Chart: _____
Date: _____

Baton Rouge Orthopaedic Clinic, LLC

When you return this form to the receptionist **please bring your insurance card**. We cannot bill your insurance unless you give us your current, accurate insurance information.

As a courtesy to you we will bill your insurance company for services provided. **All co-payments and unsatisfied deductibles must be paid at time of service;** our office expects payment in full from your insurance within 90 days unless otherwise specified by a contract with your insurance provider. In the event that your insurance makes payment at a later date all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage including any legal or other cost incurred in the collection of this account, if it becomes delinquent. I authorize Baton Rouge Orthopaedic clinic to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to Baton Rouge Orthopaedic Clinic.

Signed: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice
Effective April14, 2003

I have been presented with a copy of Baton Rouge Orthopaedic Clinic's **Notice of Privacy policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

Signed: _____ **Date:** _____

The person listed below has my permission to discuss my medical information:

Printed Name: _____ **DOB:** _____

Last 4 digits of SSN: _____

* This form will expire in one year.