



Dr. Tim Kavanaugh & Dr. Brian Carino
2741 DeBarr Road, Suite C210
Anchorage, Alaska 99508
Phone# 907-334-6788 ~ Fax# 907-334-6766

PATIENT NAME _____

Office and Financial Policies

We would like to thank you for choosing Alaska Bone and Joint Institute as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please contact our office at least 24 hours prior to, so as to make arrangements to reschedule your appointment.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make additional arrangements with our Customer Service Representative or Financial Coordinator.

Insurance: Please bring your insurance card with you at the time of your appointment. Your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Your insurance policy is an agreement between you and your insurance company. We are not a part of that agreement. Any remaining balance after insurance is billed is due upon receipt of that statement.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include:

- A copy of the police report
- A copy of your auto insurance
- Medical insurance
- Names and information on other parties involved.

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Return Checks/Rejected ACH Withdrawals: A \$25.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up or prior to. Please note Alaska State law allows ABJ 30 days to process all request for copies of your records, we will do our best to provide them 7-10 days. You may be charged for additional copies of your medical record.

PATIENT NAME _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Alaska Bone & Joint Institute. I understand that I am responsible for prompt payment of any portion of the charges including co-pays, deductibles and coinsurance amounts. I understand that payment of co-pay; deductibles, co-insurance amounts, and any non covered charges are expected at time of service, as well as any prior balance due that I may owe. I agree to be responsible for all attorney fees, court costs, and collection fees in the event of default of payment of my charges.

Signed _____ **Date** _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to ABJ to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of

(Print Name)

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that ABJ reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on ABJ's website, available at each office or I may request a copy be sent to me by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office

Signed _____ **Date** _____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of ABJ's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that ABJ has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed _____ **Date** _____

If you are not the patient, please specify your relationship to the patient _____