Commonwealth Sport and Spine

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General Acknowledgement and Waiver

Payment is due at the time of service. Payment arrangements may be available by request and will be enforced.
You may receive a statement/invoice if you (do not present the following at the time of your visit):

- A referral/authorization/referring script from your Primary Care Physician.
- A current copy of the insurance card every date of service.
- Are a self pay patient
- Have a deductible or co-insurance
- If I am not actively covered by a participating insurance plan
- If insurance determines our treatment plan is not medically necessary despite our indications or judgment call by our health care professionals deeming it medically necessary.

Acknowledgements:

- I imply consent to test my blood for infectious disease if an employee has had an exposure as a result of my treatment for any reason.
- I have read the HIPPA Policy Act and am aware & understand that information is accessible by all Commonwealth Sport and Spine providers for continuity of care. All other persons requesting the information must have a release forms signed by you.
- I authorize my insurance to pay Commonwealth Sport and Spine directly, and to immediately pay the practice if my insurance should pay me instead.

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Patient Signature Date

****MEDICARE PATIENTS ONLY- CONTINUE & SIGN BELOW****

Medicare and or your private insurance carrier will only pay for services that determines to be 'reasonable and customary' under Section 1862 (a) (1) of the Medicare law. It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done or that we provide.

Private and Commercial insurances will deny coverage for the following reasons:

A. Patient policy has terminated at time of service and/or patient did not present front desk with a current insurance card
B. Have exceeded the cap of $1,840 per calendar year for out-patient therapy

If Medicare and/or my commercial insurance should deny any or all charges and/or I do not present any of the items above, I agree to be personally and fully responsible for any and all balances due.

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Patient Signature Date