



Patient Agreement

In order to establish and maintain a physician-patient relationship with our practice, the following terms must be acknowledged by the patient or responsible party (parent, guardian, etc):

Authorization for release of information

I authorize University Orthopaedic Associates, LLC to release to any medical insurance company, health plan, affiliated entity, or pharmaceutical company records needed to determine responsibility for medical benefits and to obtain reimbursement for professional services rendered or needed.

Signature _____ Date _____

Professional Fees

I understand that I am financially responsible for any and all charges for professional services, whether or not paid by an insurance carrier or health plan. Exceptions are when patient financial responsibility is limited by statutory regulation (such as an authorized Workers' Compensation claim, Medicare fee schedule, Motor Vehicle fee schedule) or by managed care (HMO, PPO, etc) contract.

In those instances in which the Doctor is to be paid by my insurance carrier, I

- a) Understand that it is my responsibility to pay, in a timely manner, any deductible, co-payment, and "non-covered" services (ie: items which may not be covered by particular insurance plans, such as crutches, braces, etc)
- b) Request that payment of authorized medical benefits be made on my behalf and assigned to University Orthopaedic Associates, LLC.
- c) Understand that in the event my insurance carrier issues payment directly to me it is my responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to University Orthopaedic Associates, LLC.

Signature _____ Date _____

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports, or other paperwork may require a fee, paid in advance, related to the amount of the preparation involved. Please allow 5 business days for completion of any disability forms.

Medical-Legal Reports/Testimony

I acknowledge this office's policy regarding medical-legal reports and testimony. Upon proper written authorization and pre-paid copying/clerical/postage fees, copies of medical records will be provided. The doctors do not testify, nor make court appearances. Permanency evaluations and narrative reports are prepared at their discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek further orthopaedic treatment elsewhere. Records will not be released until patient's balance is paid in full, unless essential for medical care.

Initials _____ Date _____

Managed Care

In order for any Managed Care agreement/fee schedule to be applicable and valid,

- a) The patient must provide proof of coverage (valid insurance ID card) at the time of service
- b) Any required written authorization/referral must be provided at the time of service
- c) Any managed care co-payment is due at the time of each office visit

Initials _____ Date _____

Continued on Back

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Timothy M. Hosca, MD

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Jeffrey R. Bechler, MD

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Somerset County

4810 Belmar Boulevard, Ste 102
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Workers' Compensation/No-Fault Accidents

It is the patient's responsibility to clearly identify those medical injuries/conditions, which he/she believes are due to a motor vehicle accident, or are work related at the time of the initial visit.

Workers' Compensation Claims

In order for this office to submit a claim for medical services to be covered by Workers' Compensation, we must receive written (letter or fax) authorization from the employer or its Workers' Compensation Insurance Carrier prior to the initial office visit. The patient is responsible for any charges for professional services, which are denied due to lack of proper authorization.

Insurance claims for work related injuries and conditions must be submitted via Workers' Compensation and cannot be billed to the patient's private insurance (managed care or otherwise) unless Workers' Compensation coverage has been denied, does not exist, or your case has been settled.

Motor Vehicle (PIP) Claims

Insurance claims resulting from Motor Vehicle accidents must be submitted to your Motor Vehicle (PIP) carrier and cannot be billed to patient's private insurance unless PIP coverage has been denied, does not exist, or private insurance was selected as the primary carrier. The patient is responsible for any deductibles or co-payments, under their PIP coverage. I agree to have a lien placed against any settlement I receive due to this accident to pay any open balances due to University Orthopaedic Associates, LLC.

Initials _____

Date _____

X-Rays

The x-rays performed in our office constitute an integral part of the medical records. Fees for x-rays are for the professional services rendered and medical information obtained, and are not to be misconstrued as a purchase of the films. Our practice reserves the right to keep all original films, and in such cases will arrange for copying of any requested x-rays at a fee. Please allow a minimum of 72 hours for x-ray copying.

Cost of Collection

If this account becomes delinquent, I may be responsible for additional billing costs; and if this account is assigned to a collection agency or attorney for collection, **I agree to the addition of a collection surcharge of \$50.00 or 19% of the balance owed**, whichever is greater. I acknowledge a fee of \$30.00 or the actual bank charge, whichever is greater, for any returned check.

A photocopy of this form shall be considered as valid as the original.

Date

Signature of patient (or parent/guardian)

Printed name of patient (or parent/guardian)

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