Neal L. Rockowitz, M.D., P.C.
Rockowitz Orthopaedic Center/R.O.C.
Physician-Patient Financial Agreement

MEDICAL INSURANCE: HMO, PPO, Medicare, etc. The PATIENT portion (co-pay, deductible, account balance, etc.) is due at the time of service. It is the PATIENT'S responsibility to verify benefits and pay their portion PRIOR TO THE VISIT.

INDUSTRIAL INJURY: Payment for the INITIAL and subsequent visits (while the claim is open) is pre-authorized and covered by the carrier. The PATIENT is responsible for payment if treatment is rendered after the claim becomes INVALID OR CLOSED.

NO INSURANCE COVERAGE: Full Payment is due at the time of service, unless PRIOR ARRANGEMENTS have been made. We will bill Out-of-Network Insurance as a courtesy.

NO SHOW/LATE CANCELLATION: A $25 fee will apply if a PATIENT misses an appointment with "NO" OR "LESS THAN" 24 HOUR NOTICE. The "No Show' fee must be paid before additional appointments will be scheduled.

Is there ATTORNEY REPRESENTATION FOR THIS CONDITION? Yes____ No____
If "Yes" please complete the portion below:

____

Attorney Name   Telephone Number

Is there AUTOMOBILE INSURANCE COVERAGE INVOLVED? Yes_____No_____
If "Yes" please complete the portion below:

____

Auto Insurance Company   Telephone Number

Finance Charges

If the entire "Patient Portion" balance is not paid within 30 days of the billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. This finance charge will be a periodic rate of 1.75% per month, or a minimum monthly charge of $5.00, which is an ANNUAL PERCENTAGE RATE OF 21% applied to the last month's balance. In the case of default of payment, PATIENT or GUARDIAN promise to pay any interest on the balance due, as well as any collection costs and attorney's fees incurred to effect collection on the account. Account Balance is due at time of Visit.

I UNDERSTAND AND AGREE TO THE ABOVE POLICIES:

X__________________________ X ________________________ X __________

PATIENT OR GUARDIAN NAME   SIGN   DATE

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