Jacksonville Orthopaedic Institute
We'll treat you like a pro!

Agreement To Pay Charges

I understand and agree that:

○ It is my responsibility to provide accurate insurance or other third party payor information to Jacksonville Orthopaedic Institute (JOI). I understand that as a service to me, JOI will file most insurance or other third party payor claims.

○ If the services provided by JOI are not "covered services" or are not "eligible" for payment under either insurance or other third party coverage due to JOI's not being a participating or eligible provider, then I am responsible for payment of JOI's charges connected with such services; provided that JOI is not precluded from imposing such charges by the terms of any third party payor agreement to which JOI is bound, or by applicable law or regulation.

○ All co-payments, deductibles, or, unless otherwise specifically agreed by JOI in writing, outstanding account balances, must be paid at the time of my visit. All charges connected with JOI's services not covered by any insurance or other third party coverage are due and payable within 30 days of services rendered. Amounts not paid within such 30 day period shall be deemed to be delinquent and may bear interest at the rate of 1 1/2 % per month (18% per annum). If the delinquent account is referred for collection, I will pay JOI's attorney's fees, court costs and/or collection agency fees associated with the collection process. If litigation results, the amount of such attorney's fees will be determined by a court and not a jury. This Agreement has been executed and delivered in, and shall be interpreted, construed and enforced pursuant to and in accordance with the laws of the State of Florida without regard to choice of law considerations. The state court forum of any litigation shall be in Duval County, Florida, in the court of appropriate jurisdiction, and the federal court jurisdiction will be in the Middle District of Florida in Duval County, Florida.

Assignment of Insurance Benefits and Release of Medical Information

I hereby:

○ Assign to JOI the benefits of all insurance policies otherwise payable to the patient for services rendered.

○ Authorize JOI to submit insurance claims to insurance companies or third party payors with respect to which JOI is participating provider and to apply insurance proceeds or other third party payments for covered services to JOI and to make refunds to insurance companies or other third party payment plans or rules if refunds are due under the provision of such insurance policies or other third party payment plans or rules.

○ Assign all rights, as the insured, to bring an action against my insurance company or other third party payor for benefits due under the insurance policies or other third party payor plans or rules.

○ Authorize JOI to release information and/or copies of the patient's medical records to any guarantor of payment on my account, any insurance company (including worker's compensation carriers and patient's employer) or other third party payor(s) from which benefits may be available.

By signing my name below, I certify that I have read, understand and agree to the foregoing, received a copy thereof, and am personally empowered, or am duly authorized by the patient, as patient's parent or guardian agent, to execute and enter into this Agreement.

PATIENT

_____
Patient Name (Print)

_____ _____
Patient's Signature Date

PARENT/GUARDIAN

_____
Parent or Guardian (Print)

_____ _____
Parent or Guardian's Signature Date

GUARANTOR

_____ _____
Unconditional Guarantor (other than Patient or if different from Parent/Guardian) Date