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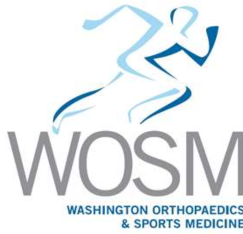

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Stephen S. Haas
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Randall J. Lewis
Benjamin S. Shaffer

( ) Out of Network Waiver for Medical Services (for commercial policies only)

I, ________________________________ , understand that I am choosing to see Washington Orthopaedics and Sports Medicine physicians outside of my commercial/group/individual insurance plan. By doing so, I understand that I am fully responsible for all medical billings incurred as the result of any visit to Washington Orthopaedics and Sports Medicine, P.A.

Signature: **Date:**

( ) Secondary to Medicare: Out of Network Waiver (for Medicare enrollees only)

I, ________________________________ , understand that I am choosing to see Washington Orthopaedics and Sports Medicine who participates with Medicare, but is outside of my **secondary (and tertiary)** insurance plan's network. By doing so, claims will be submitted on my behalf to both Medicare and my secondary insurance. I understand that I may be billed for any deductible or coinsurance not paid in full by my secondary insurance policy.

Signature: **Date:**

( ) Durable Medical Equipment Waiver for all Patients

I, ________________________________ , understand that I am fully responsible for durable medical equipment purchased at Washington Orthopaedics and Sports Medicine not covered by my insurance policy.

PLEASE NOTE

_________ **(Initial)** According to the OSHA (Occupation Safety and Health Administration) guidelines, medical equipment purchased and taken off site is not allowed to be returned.

Signature: ____ **Date:** ____________________

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Collections Policy

_________ **(Initial)** Accounts sent to collections are subject to a collection fee assessment.

_________ **(Initial)** Accounts sent to collections will have previous courtesy adjustments reversed to the reponsiblity of the account holder.

Signature:_________________________________

Date: ___________________________