The Centers for Advanced Orthopaedics

8206 Leesburg Pike, Suite 409
Vienna, VA 22182
Tel: (703) 288-0094
Fax: (703) 288-0673
www.novaosmc.com

NOVA Orthoapedics and Sports Medicine Center
Vinh B. Tran, M.D., F.A.A.O.S

Authorization for Claims, Payment AND Review

Assignment and Coordination of Insurance Benefits: I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefit plan(s) to NOVA Orthopaedics & Sports Medicine Center, PC (hereafter referred to as "NOVA OSMC") for services rendered to me. The direct payment hereby assigned and authorized includes any hospital and/or medical insurance benefits to which I am otherwise entitled, including any Major Medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to NOVA OSMC for which services rendered to me during the applicable periods of medical care.

Unauthorized, Non-Covered, or Out of Plan Services: I understand that if my insurance company or health maintenance organization does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the serviced rendered during this admission, office visit or surgical procedure. I agree to be fully responsible for payment to NOVA OSMC for providing services to me/the patient for this admission or any service if determined by my insurance or health maintenance organization to be a non-covered service. I also understand and acknowledge that in case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. I also understand that physicians of NOVA OSMC may not be a participating physician member of my managed care health. In the event that my managed health care plan does not reimburse these services provided to me, I acknowledge that I will be responsible for any balance that it declines to pay for such services.

Authorization to Release Information and Process Claims: I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this episode of care or any related services, which may include records relating to the treatment for substance abuse to my insurance carrier(s), managed care plan or other payor, including past and/or present employer(s), Medicare, Medicaid, or Tricare, authorized private review entities of NOVA OSMC and/or independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and, as applicable, the Social Security Administration, the Centers for Medicare & Medicaid Services, the Peer Review Organization acting on the behalf of the federal government and/or any other federal or state agency for the purpose(s) of satisfying billed charges and/or facilitating utilization review and/or conducting chart review and market surveys and/or otherwise complying with the obligations of state or federal law. A photocopy of this authorization may be honored.

For Medicare Recipients Only: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to NOVA OSMC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agent any information needed to determine these benefits or the benefits payable for the related services. In the case of

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Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment. My signature acknowledges receipt of "An Important Message from Medicare" on the signed date.

Responsibility for Payment: In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account is placed with an attorney or collection agency to obtain payment, I agree to pay responsible attorneys' fees and other associated collection costs.