Jansen Orthopaedic Clinic, LLC
L. Dean Jansen M.D.
2124 N. Biomet Drive
Warsaw, IN 46582
P: (574)267-2663
F: (574)267-4408

Agreement to Pay

Patient Name: _____
DOB: _____
Date: _____

In consideration for the services rendered by the Jansen Orthopaedic Clinic to me, (us), I (we) agree to pay the Jansen Orthopaedic Clinic for all services and charges as are ordered by the attending physician and/or certified physician assistants under their supervision in accordance with the terms and policies of Jansen Orthopaedic Clinic. Further, I (we) understand that if my (our) health insurance coverage includes preauthorization of notice requirements and/or services to be provided by Jansen Orthopaedic Clinic which are not covered by the policy, and/or if I (we) fail to provide timely proof of health insurance coverage (whether Medicare, Medicaid, commercial insurance, or any other insurance provider), I (we) accept responsibility for payment of all services which may be denied insurance coverage due to exclusion from covered services, noncompliance with preauthorization or notice requirements, or any other reason for denial. Further, in the event the account is not paid in accordance with the financial arrangements made at the time of service, I (we) agree and guarantee to pay collection costs, including reasonable attorney fees and interest from the date of demand.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Spouse Date

_____ _____
Witness Date

Benefit Assignment

I hereby assign to Jansen Orthopaedic Clinic all physician expenses and /or certified physician assistant expenses or other surgical or treatment expenses and benefits which are due or to become due to me as a result of medical services to the patient listed above. I hereby authorize the payments to be paid directly to Jansen Orthopaedic Clinic for any services furnished by Jansen Orthopaedic Clinic. I further understand I am responsible to Jansen Orthopaedic Clinic for any payments made directly to me.

_____ _____
Signature of Patient or Guarantor Date

_____ _____
Signature of Spouse Date

_____ _____
Witness Date

Medicare Statement

I request that payment of authorization Medicare benefits be made to Jansen Orthopaedic Clinic on my behalf for any services furnished me by Jansen Orthopaedic Clinic. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____
Patient HICN

_____ _____
Patient/ Representative Signature Date

Medigap Statement

I request that payment of authorized Medigap benefits be made to Jansen Orthopaedic Clinic for any services furnished to me by Jansen Orthopaedic Clinic. I authorize any holder of information about me to release to _____
any information needed to determine these benefits or the benefits payable for related services.

_____
Patient HICN

_____
Patient/ Representative Signature