



17853 St. Rt. 31, Suite A
Marysville, Ohio 43040
Phone: 937-578-4200
Fax: 937-578-4323

Douglas S. Skura, M.D.

Mark Stover, D.O., FAOAO

NOTIFICATION TO ALL PATIENTS

The rigid regulations of the insurance industry require us to have you sign the following release.

PLEASE READ THEM ALL CAREFULLY

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf, however, if my insurance company denies payment for any reason (i.e. non-covered services, does not pay for preventive medical visits, failure to secure a referral from my primary care physician, etc.) I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement constitutes a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

Insurance Release: I hereby assign all medical benefits to which I am entitled to Memorial Hospital of Union County d/b/a Marysville Orthopedics in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owed as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

Consent to Treatment: I do hereby consent to such treatment, by the authorized personnel of Memorial Hospital of Union County d/b/a Marysville Orthopedics as may be dictated by prudent medical practice, of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Responsible Party Signature: _____ **Date:** _____

HIPAA Receipt Confirmation:

I have received a copy of Memorial Hospital of Union County d/b/a Marysville Orthopedics Notice of Patient Information Practices.

Responsible Party Signature: _____ **Date:** _____

Office personnel ONLY: Attempted & Refused: _____