Central Orthopedics & Sports Medicine, P.C.
Liability Patient Policy and Agreement

Policy: Central Orthopedics & Sports Medicine, P.C. (COSM) will provide services to patients involved in a liability injury. COSM will consistently apply a method of billing and collecting from patients who have filed a liability claim. Once a liability claim is established claims cannot be sent to health insurance or Medicare. Patients involved in a liability injury will read, understand and agree to the policy detailed below by signing at the bottom of the policy. COSM and the patient will retain a copy of this policy and agreement.

- Patients with a liability injury will be identified when they initially contact the office for an appointment. A Liability injury is defined as a patient who (i) has an injury that is the fault of another party; (ii) is not filing a claim to a health insurance plan, Medicare or Medicaid; and (iii) is not eligible for worker's compensation coverage.

- Patients with a liability injury will provide the following information:

  Date of the Accident: _____ Location of accident: _____

  Third party liability insurance company (i.e.: auto or business owner insurance)
  Company Name: _____ Contact Name: _____
  Company Address: _____
  Contact Phone: _____ Contact Email: _____
  Claim Number: _____

  Attorney Representing the patient: Name:_____
  Address: _____
  Phone: _____ Email:_____

- **Liability injury patients will be required to pay an initial deposit on their COSM account, up front, at the time of service, in the amount of $250. Charges above $250 can be paid with a Payment Plan arranged with COSM's Business Office.**

- **High cost products purchased by the practice, such as visco supplementation agents, are excluded from the $250 deposit and require payment in advance of treatment.**

- **Services with COSM will NOT BE BILLED to the patient's medical insurance, Medicare, Medicaid or workman's compensation.**

- **Once the patient receives a settlement from the responsible party all COSM charges must be paid in full within 10 days.**

I have read and understand the COSM Liability Patient Policy and Agreement. I understand that the patient or guarantor signing below is financially responsible for all charges for medical services provided by COSM. I agree to pay for any services that are not covered by the third party liability company listed above.

_____ _____
Printed Patient Name Patient/Guarantor Signature

_____ _____
Date Printed Guarantor Name