Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office financial policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

I. Release of Information for Billing purposes

I agree that Boston Sports & Biologics will release to and receive from my insurer(s), other payers, or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for billing, collection or payment of claims for services provided.

This information may include my identity, diagnosis, prognosis, and treatment for physical illness, injury, surgical procedures, progress notes, and all other information contained in patient care records to the extent that such records are needed for billing or collection of benefits due to me from any payer. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed

II. Insurance

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill your insurance company on your behalf.
2. It is your responsibility to bring your most current insurance card to appointment. It is our responsibility to verify that we accept your health insurance plan. If we do not accept your health insurance plan you will be notified prior to providing any health care service.
3. If we are not contracted with your insurance company, you will be informed that we do not participate in your health insurance plan at the time of scheduling your appointment. In we do not accept your insurance we will be considered "out-of-network," and you will be provided with a good faith estimate of what will be billed and what would be your potential out-of-pocket cost as detailed in section IV.
4. You will be verbally provided with whether we accept your insurance plan at all of your follow-up visits. If we are an "out-of-network" provider you will be provided with this information in writing, and will be asked to sign a waiver acknowledging that this information has been provided to you.
5. You are not required to get care "out-of-network." You can choose a provider or facility in your plans network.
6. Boston Sports & Biologics does not provide referrals to see another provider. We may provide suggestions for other physicians or hospital organizations, but if you require a referral to see another provider this will have to be obtained from your primary care physician.

7. To see one of the physicians at Boston Sports & Biologics you may require a referral from your primary care physician. The established rules for referrals vary widely. Some insurance plans allow patients to self-refer to physicians. Many HMOs require that referrals be approved by your PCP prior to any scheduled appointment with a specialist. You are responsible for calling your PCP's office to assess your needs before your visit.

8. If you do not have a referral on file prior to the visit, you can request to reschedule the visit. If you do not have a referral on file prior to the visit, and you want to proceed with the visit you will asked to sign a waiver acknowledging that you understand that without a referral, your health care insurer could refuse to pay and you could be held responsible for the entire cost of the office visit (not just the co-payment or deductible).

9. Uninsured (or self-pay) individuals can expect charges for receiving certain health care items and services. You have a right to a good faith estimate as detailed in section IV

10. If we are "out-of-network" and do not provide a written notice that we do not participate in your health insurance plan and provide you with a waiver, then we will only bill you for the amount that would have been required as a copayment, coinsurance or deductible as if we were covered by your health insurance plan.

III. Consent to Treatment Using Telehealth/Telemedicine or Email Communication

1. I consent to treatment involving the use of electronic communication, whether by telephone telehealth/telemedicine visits, video telehealth/telemedicine visits or by email communication.

2. While the likelihood of risks associated with electronic communication in a secure environment is minimal, the risks are nonetheless real and important to understand. Risks of electronic communication include, but are not limited to: technical problems or equipment failures that could result in lost information or delays in treatment and that it is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

3. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease.

4. I understand that I have a right to withhold or withdraw my consent to the use of electronic communication in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

5. Boston Sports & Biologics will operate under the assumption that insurance companies will reimburse for electronic communication. I consent to forwarding my information to

a third part as needed to receive these services, and that existing confidentiality protections outlined in this document apply to these visits and/or communications as well.

6. I understand that electronic communication, whether by telephone telehealth/telemedicine visits, video telehealth/telemedicine visits or by email communication, will be billed in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s). Boston Sports & Biologics will collect Co-Pays, Co-Insurance, and deductibles as required by your insurance company. Boston Sports & Biologics will also waive Co-Pays, Co-Insurance, and deductibles as required by your insurance company.
7. If electronic communication, such as telehealth or telemedicine visits or email communication, are not covered services then the first communication will be free. If electronic communication are not a covered insurance by your insurance company, then Boston Sports & Biologics will attempt to scheduled additional visits in the office as "covered visits" or we will provide the option for self-pay telehealth or telemedicine visits for any subsequent calls if these are not covered services.
8. I understand that electronic communication should not be used for emergencies or time-sensitive matters. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

IV. Right to a Good Faith Estimate

1. As a patient you have the right to request a good faith estimate for Under Section 2799B-6 of the Federal Public Health Service Act. A Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
2. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.
3. According to Massachusetts law, *An Act Promoting a Resilient Health Care System that Puts Patients First* ("*Patients First*"), financial information regarding scheduled procedures or services will be provided verbally at the time of scheduling the procedures or service. A written invoice with the good faith estimate will be provided within 3 business days upon request. If the procedure is a self-pay procedure or "out-of-network" then the invoice will be provided in writing prior to the procedure.
4. In some cases, we maybe unable to quote a specific cost in advance because they cannot predict the specific treatment you will need or your responsibility according to your specific insurance plan. At your request, we will provide an *estimated* maximum for the medical procedure or health care service. There are no facility fees for in-office visits or in-office procedures.

V. Financial Responsibility

1. According to your insurance plan, you are only responsible for paying your share of the cost (any and all co-payments, deductibles, and coinsurances).
2. Uninsured (or self-pay) patients or patients undergoing a procedure that is not covered by their insurance plan will be provided with an invoice with a good faith estimate of charges due for the services rendered at the appointment. Unknown or unexpected costs that may arise during treatment, and will be discussed with the patient providing a verbal quote that may be higher or lower than the initial estimate. No procedure will be performed that will alter the initial estimate without written notice and consent agreement by the patient.
3. Uninsured (or self-pay) patients are expected to pay for services in FULL at the time of the visit. Patient that are scheduled for non-covered procedures are expected to pay for services in FULL at the time of the visit.
4. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. Any outstanding balance unpaid for more than 90 days may be forwarded to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice. *If special circumstances make immediate payment impossible, payment arrangements must be approved by our business office staff.*

VI. Grievances

1. If you believe you've been wrongly billed, you may contact our office at (781) 591-7855 or info@bsbortho.com.
2. To file a complaint with the Board of Registration in Medicine's (BORIM) Consumer Protection Division: https://www.mass.gov/submit-a-complaint

Document Acknowledgement

I certify that I have read and understand the foregoing Financial Agreement, and that I am competent and authorized to execute this document. I understand that I am not entitled to make any changes or alterations to this legal non-negotiable document. I will notify Boston Sports & Biologics should my insurance coverage (including eligibility for Medicare or Medicaid), home address or other personal contact information change.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient/Legal Representative (Print)	*Relationship*	*Date (MM/DD/YYYY)*

Patient/Legal Representative Signature

Assignment of Benefits

VII. Assignment of Benefits

In considering for the care provided by Boston Sports & Biologics, I authorize payment of medical benefits directly to Boston Sports & Biologics from any third-party insurance, plan, or entity, covering such expenses. If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Boston Sports & Biologics for any and all care. I agree that these benefits, otherwise payable to me, shall be paid directly to Boston Sports & Biologics and that this agreement cannot be revoked without my and Boston Sports & Biologics' consent.

If I receive payment directly from my insurance company, it is my responsibility to forward it to Boston Sports & Biologics for payment within 30 days of receipt.

I have read and understand that I am assigning payment from my insurance benefits directly to Boston Sports & Biologics

Patient/Legal Representative (Print)	*Relationship*	*Date (MM/DD/YYYY)*

Patient/Legal Representative Signature