Thank you for choosing Powder River Orthopedics & Spine-A Campbell County Clinic as your healthcare provider. We are committed to providing quality care and service to all of our patients. Below is a general outline of patient responsibilities and information. We will do our best to ensure a positive experience.

It is your responsibility to know your own insurance benefits:

- Including whether we are a contracted provider with your insurance company
- Your covered benefits and exclusions in your insurance policy
- Any pre-authorization requirements of your insurance company

We will attempt to confirm your insurance coverage prior to any surgeries:

- It is your responsibility to provide current and accurate insurance information

We will send your claim(s) to your insurance carrier

- It is your responsibility to provide information to your insurance carrier in a timely manner should they request it
- We will send you statements indicating the balance you owe, we expect payment on said balance within 30 days

We will discuss your account and circumstances

- It is your responsibility to contact us and make a significant effort to meet financial obligations

*__Insurance Disclaimer:__ "A quote of benefits is not a guarantee of payment unless otherwise required by law. All benefits are subject to the terms, conditions, limitations, and exclusions under the member's policy, including the patient's effective status on the actual date of service. ***All claims should be filed to the state in which the service was rendered unless otherwise specified under the member's contract***

I ACKNOWLEDGE I HAVE READ THE ABOVE STATEMENT:

X_____ (PRINT PATIENT NAME)

X (Signature of Patient- Parent/Guardian) X

(Date)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that Powder River Orthopedics & Spine-A Campbell County Clinic has made available it's "Notice of Privacy Practices" for me to review and that I may request a copy if I so desire.

X_____ X_____

(Signature of Patient – Parent/Guardian) (Date)

NARCOTIC MEDICATION AND REFILL POLICY

The care of orthopedic musculoskeletal injuries or surgical intervention can obviously be painful. I understand this pain/and or discomfort may require the use of narcotic pain medication to help ease the pain. I agree that I will not obtain prescriptions or refills for narcotic medication from any other physician while under the care of PROS physicians. Patients may be refused additional care and/or treatment without notice for violating the agreement not to obtain narcotics from any other physician while under the care of PROS physicians.

X_____ X_____

(Signature of Patient – Parent/Guardian) (Date)