Orthopaedic & Spine Surgery Institute
19450 Deerfield Ave, Suite 275
Lansdowne, VA 20176
www.OSSI-Virginia.com

Ali Moshirfar, M.D.
George Ibrahim, M.D.
Meredith Soriano, NP-C
703-723-OSSI (6774)

AUTHORIZATION FOR CLAIMS AND PAYMENTS

I hereby authorize **Orthopaedic & Spine Surgery Institute** to apply for benefits on my behalf. I request that payment for covered services is made directly to **Orthopaedic & Spine Surgery Institute** unless it indicates otherwise. I certify that the information I have provided about my insurance coverage is correct and further authorize the release of information, medical and other, as necessary in the processing of claims. I acknowledge and understand that I am responsible for the payment of all services rendered to me or any member of my family.

Should any employee or other individual be exposed to my blood or bodily fluids, I hereby consent to testing my blood for Hepatitis virus and AIDS (HIV) virus as necessary.

I hereby certify that the information I have provided is true and correct to the best of my ability.

YOUR SIGNTURE BELOW constitutes that you fully understand, acknowledge, and agree with the above policies of **Orthopaedic & Spine Surgery Institute.**

Patient or Guarantor Signature: _____ **Date:** _____

Patient or Guarantor Printed Name: _____ **Relationship to Patient:** _____

CANCELLATION POLICY

Orthopaedic & Spine Surgery Institute requires 24-hour advance notice for cancelled appointments and/or procedures. Our receptionists are available from 8:30 am to 4:30 pm Monday through Friday to accept your calls to cancel or reschedule appointments. You may also cancel appointments by sending a message through the patient portal.

Any appointment or procedure that is not canceled within a 24 hours' notice will be subject to a cancelation fee as follows:

OFFICE VISIT: $35.00

PROCEDURE VISIT: Will vary based on location and procedure type

The cancelation fee is the responsibility of the patient/ guarantor and will not be billed to your insurance company.

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Patient or Guarantor Signature: _____ **Date:** _____